Application Granted. SO ORDERED.

Dated: May 23, 2025
New York, New York

/s/ John G. Koeltl
John G. Koeltl, U.S.D.J.

Zeng v. Chell, 19 Civ. 03218 – Motion to Seal Exhibits (FRCP 5.2(d))

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

XIAMIN ZENG,
Plaintiff,
-against-
Case No. 19 Civ. 03218 (JGK) (KHP)
JOHN CHELL, ET AL.,
Defendants.

MOTION TO FILE EXHIBITS UNDER SEAL PURSUANT TO FED. R. CIV. P. 5.2(d)

Plaintiff Xiamin Zeng, proceeding pro se, respectfully moves this Court pursuant to Federal Rule of Civil Procedure 5.2(d) for permission to file unredacted versions of Exhibits A, B, C, E, G, and J, attached to the Supplemental Motion to Vacate Judgment (filed May 16, 2025), under seal for in camera review. This motion supports the Supplemental Motion (ECF Nos. 152, 154, 157) and complies with the Privacy Protection Statement therein (page 8).

Dated: May 16, 2025
New York, New York

Xiamin Zeng
Plaintiff Pro Se
110 Columbia St, Apt 1A
New York, NY 10002
amyzane77@gmail.com
929-257-1509

Zeng v. Chell, 19 Civ. 03218 – Motion to Seal Exhibits (FRCP 5.2(d))

I. Purpose of Motion

1. This motion seeks to protect sensitive personal information in Exhibits A (15 pages), B (15 pages), C (7 pages), E (12 pages), G (2 pages), and J (1 page), redacted in the public filing per Fed. R. Civ. P. 5.2(a), the HIPAA Privacy Rule (45 C.F.R. § 164.514), and SDNY Local Rule 5.2(b). Unredacted versions are necessary for the Court's review of Plaintiff's claims under 42 U.S.C. § 1983, alleging deliberate indifference, counsel neglect, and Defendants' non-disclosure.

II. Redacted Information and Justification

2. The redacted information includes:
a. Social Security Numbers (Exhibits A, B, E): Protected under Fed. R. Civ. P. 5.2(a)(1).
b. Birth Dates (Exhibits A, B, E): Protected under Fed. R. Civ. P. 5.2(a)(2).
c. Third-Party Addresses and Contact Information (Exhibits A, B, E): Protected to ensure privacy of non-parties, per HIPAA and SDNY Local Rule 5.2(b).
d. Family Court Docket Numbers (Exhibit C): Protected under N.Y. Fam. Ct. Act § 166 to maintain confidentiality of child welfare proceedings.
e. Medical Insurance Records (Exhibit J): Protected under HIPAA (45 C.F.R. § 164.514) as protected health information relevant to medical neglect claims.
These redactions align with the Supplemental Motion's Privacy Protection Statement (page 8). Redacted Exhibit E is served to Defendants, while unredacted Exhibits A, B, C, E, and J are filed under seal for in camera review only. Exhibit G is filed publicly without redactions, as it contains only signatures, printed names, and publicly available information, with no sensitive data requiring protection.

III. Relevance to Case

3. The unredacted exhibits (A, B, C, E, J) are critical to Plaintiff's § 1983 claims, demonstrating:
- Deliberate indifference to medical needs (Exhibit J, medical insurance records documenting a Medicaid coverage gap).
- Excusable neglect by counsel and damages from alleged violations (Exhibits A and B, HIPAA releases, psychotherapy notes releases, and medical/insurance authorizations; Exhibit E, discovery cover letter detailing tax returns, employment records, medical record authorizations, healthcare providers, damages, and related cases).
- Defendants' non-disclosure and counsel neglect (Exhibit C, 2018–2019 tax returns, criminal court record, ACS court record, and job record).
Exhibit G (WilmerHale retainer agreement signature page and screenshots of NYCHA representation) is filed publicly without redactions, demonstrating counsel's conflict of interest. Filing under seal ensures privacy while enabling in camera review, consistent with *Haines v. Kerner*, 404 U.S. 519 (1972), granting pro se leniency.

IV. Request for Relief

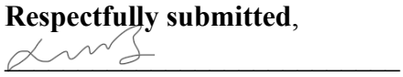
4. Plaintiff respectfully requests:
a. Permission to file unredacted Exhibits A, B, C, E, and J under seal pursuant to Fed. R. Civ. P. 5.2(d).
b. In camera review of unredacted exhibits to evaluate the Supplemental Motion's claims.
c. Maintenance of redacted versions of Exhibits A, B, C, E, and J on the public docket, per Fed. R. Civ. P. 5.2(a), with Exhibit G filed publicly without redactions.
d. Any further relief the Court deems just and proper.

V. Certification of Service

5. I certify that on May 16, 2025, I emailed this motion to Defendants' counsel at zreszytn@law.nyc.gov and ecf@law.nyc.gov, per SDNY Local Rule 5.2(b). Unredacted Exhibits A, B, C, E, and J are filed under seal for court review only and not served on Defendants. Redacted Exhibits A, B, C, E, and J, and unredacted Exhibit G are served on Defendants.

Dated: May 16, 2025

Respectfully submitted,



Xiamin Zeng
Plaintiff Pro Se
110 Columbia St, Apt 1A
New York, NY 10002
amyzane77@gmail.com
929-257-1509

CC:

Zoe Reszytniak, Esq.
Assistant Corporation Counsel
New York City Law Department
100 Church Street
New York, NY 10007
zreszytn@law.nyc.gov
ecf@law.nyc.gov

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
XIAMIN ZENG	09/09/1981	747-94-9901

Patient Address: 110 Columbia Street, Apt 1A New York, NY 10002

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Evelyn Alexander, Social Services, University Settlement Society, 184 Eldridge St, New York, NY 10002

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis Esq 100 Church Street, New York NY 10007

9. (a). Specific information to be released:

☒ Medical Record from (insert date) 1/1/2018 to (insert date) present

☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: *(Indicate by Initialing)*

XZ **Alcohol/Drug Treatment**

XZ **Mental Health Information**

XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here_____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a government agency, listed here:

_____

(Attorney/ Firm Name or Government Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☒ Other: Litigation	upon the exhaustion of appeals
12. If not the patient, name of person signing form:	13. **Authority** to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 7/8/20

Signature of patient or representative authorized by law.

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
XIAMIN ZENG	09/09/1981	747-94-9901

Patient Address: 110 Columbia Street . Apt 1A New York. NY 10002

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Andrew Chan MD. 17 Elizabeth St. #502 New York. NY 10013

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis Esq 100 Church Street. New York NY 10007

9. (a). Specific information to be released:

☒ Medical Record from (insert date) 1/1/2018 to (insert date) present

☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: *(Indicate by Initialing)*

XZ **Alcohol/Drug Treatment**

XZ **Mental Health Information**

XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here_____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a government agency, listed here:

_____

(Attorney/ Firm Name or Government Agency Name)

10. Reason for release of information:
☐ At request of individual
☒ Other: Litigation

11. Date or event on which this authorization will expire:
upon the exhaustion of appeals

12. If not the patient, name of person signing form.

13. **Authority** to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 7/8/20

Signature of patient or representative authorized by law.

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
XIAMIN ZENG	09/09/1981	747-94-9901
Patient Address: 110 Columbia Street, Apt 1A New York, NY 10002		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
John Chan, PhD, 17 Elizabeth St. #409, New York, NY 10013

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis Esq 100 Church Street, New York NY 10007

9. (a). Specific information to be released:

☒ Medical Record from (insert date) 1/1/2018 to (insert date) present

☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: *(Indicate by Initialing)*

XZ **Alcohol/Drug Treatment**

XZ **Mental Health Information**

XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a government agency, listed here:

_____

(Attorney/ Firm Name or Government Agency Name)

10. Reason for release of information:
☐ At request of individual
☒ Other: Litigation

11. Date or event on which this authorization will expire:
upon the exhaustion of appeals

12. If not the patient, name of person signing form:

13. **Authority** to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 7/8/20

Signature of patient or representative authorized by law.

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
XIAMIN ZENG	09/09/1981	747-94-9901

Patient Address: 110 Columbia Street, Apt 1A New York, NY 10002

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Mount Sinai Beth Israel Emergency Room, 281 1st Ave, New York, NY 10003

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis Esq 100 Church Street, New York NY 10007

9. (a). Specific information to be released:

☒ Medical Record from (insert date) 1/1/2018 to (insert date) Present

☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: *(Indicate by Initialing)*

XZ **Alcohol/Drug Treatment**

XZ **Mental Health Information**

XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a government agency, listed here:

_____

(Attorney/ Firm Name or Government Agency Name)

10. Reason for release of information:
☐ At request of individual
☒ Other: Litigation

11. Date or event on which this authorization will expire:
upon the exhaustion of appeals

12. If not the patient, name of person signing form

13. **Authority** to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 7/8/20

Signature of patient or representative authorized by law.

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
XIAMIN ZENG	09/09/1981	747-94-9901
Patient Address: 110 Columbia Street, Apt 1A New York, NY 10002		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
New York Presbyterian / Lower Manhattan Hospital Emergency Department 170 William St, New York NY 10038

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis Esq 100 Church Street, New York NY 10007

9. (a). Specific information to be released:

☒ Medical Record from (insert date) 1/1/2019 to (insert date) Present

☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: *(Indicate by Initialing)*

XZ **Alcohol/Drug Treatment**

XZ **Mental Health Information**

XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here_____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a government agency, listed here:

_____

(Attorney/ Firm Name or Government Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☒ Other: Litigation	upon the exhaustion of appeals
12. If not the patient, name of person signing form	13. **Authority** to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 7/8/20

Signature of patient or representative authorized by law.

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
XIAMIN ZENG	09/09/1981	747-94-9901

Patient Address: 110 Columbia Street, Apt 1A New York, NY 10002

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Huachen Wei, MD. 139 Centre St #215 New York, NY 10013

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis Esq 100 Church Street, New York NY 10007

9. (a). Specific information to be released:

☒ Medical Record from (insert date) 1/1/2018 to (insert date) Present

☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: *(Indicate by Initialing)*

XZ **Alcohol/Drug Treatment**

XZ **Mental Health Information**

XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a government agency, listed here:

_____

(Attorney/ Firm Name or Government Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☒ Other: Litigation	upon the exhaustion of appeals
12. If not the patient, name of person signing form	13. **Authority** to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 7/8/20

Signature of patient or representative authorized by law.

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
XIAMIN ZENG	09/09/1981	747-94-9901

Patient Address: 110 Columbia Street, Apt 1A New York, NY 10002

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Norman Chan, MD, 202 Canal St. # 602, New York, NY 10013

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis Esq 100 Church Street, New York, NY 10007

9. (a). Specific information to be released:

☒ Medical Record from (insert date) 1/1/2018 to (insert date) present

☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: *(Indicate by Initialing)*

XZ **Alcohol/Drug Treatment**

XZ **Mental Health Information**

XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here_____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a government agency, listed here:

_____

(Attorney/ Firm Name or Government Agency Name)

10. Reason for release of information:
☐ At request of individual
☒ Other: Litigation

11. Date or event on which this authorization will expire:
upon the exhaustion of appeals

12. If not the patient, name of person signing form:

13. **Authority** to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 7/8/20

Signature of patient or representative authorized by law.

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
XIAMIN ZENG	09/09/1981	747-94-9901

Patient Address: 110 Columbia Street, Apt 1A New York, NY 10002

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Kathy Feng, AUD · 128 Mott St. #509, New York, NY 10013

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis Esq 100 Church Street, New York NY 10007

9. (a). Specific information to be released:

☒ Medical Record from (insert date) 1/1/2018 to (insert date) present

☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: *(Indicate by Initialing)*

XZ **Alcohol/Drug Treatment**

XZ **Mental Health Information**

XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a government agency, listed here:

_____

(Attorney/ Firm Name or Government Agency Name)

10. Reason for release of information:
☐ At request of individual
☒ Other: Litigation

11. Date or event on which this authorization will expire:
upon the exhaustion of appeals

12. If not the patient, name of person signing form:

13. **Authority** to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 7/8/20

Signature of patient or representative authorized by law.

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
XIAMIN ZENG	09/09/1981	747-94-9901

Patient Address: 110 Columbia Street, Apt 1A New York, NY 10002

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Jing Guo, AUD. 217 Grand St Ste 6, New York, NY 10013

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis Esq 100 Church Street, New York NY 10007

9. (a). Specific information to be released:

☒ Medical Record from (insert date) 1/1/2018 to (insert date) present

☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: *(Indicate by Initialing)*

XZ **Alcohol/Drug Treatment**

XZ **Mental Health Information**

XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here_____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a government agency, listed here:

_____

(Attorney/ Firm Name or Government Agency Name)

10. Reason for release of information:
☐ At request of individual
☒ Other: Litigation

11. Date or event on which this authorization will expire:
upon the exhaustion of appeals

12. If not the patient, name of person signing form:

13. **Authority** to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 7/8/20

Signature of patient or representative authorized by law.

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
XIAMIN ZENG	09/09/1981	747-94-9901

Patient Address: 110 Columbia Street, Apt 1A New York, NY 10002

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Jeffrey Chan Acupuncture Clinic 107 E Broadway 3 fl New York, NY 10002

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis Esq 100 Church Street, New York NY 10007

9. (a). Specific information to be released:

☒ Medical Record from (insert date) 1/1/2018 to (insert date) Present

☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: *(Indicate by Initialing)*

XZ **Alcohol/Drug Treatment**

XZ **Mental Health Information**

XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a government agency, listed here:

_____

(Attorney/ Firm Name or Government Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☒ Other: Litigation	upon the exhaustion of appeals
12. If not the patient, name of person signing form:	13. **Authority** to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 7/8/20

Signature of patient or representative authorized by law.

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

XIAMIN ZENG,

19-CV-3218 (JGK) (KHP)

Plaintiff,

-against-

RELEASE FOR PSYCHOTHERAPY NOTES

JOHN CHELL; GARY DENEZZO; GEORGE TAVAREZ; CITY OF NEW YORK; DIEGO ANDRIANZAN; DANIELLE FEBUS,

Defendants.

TO: Andrew chan. MD. Psychiatrist [Health Care Provider]
17 Elizabeth St, #501 [Address]
New York, NY, 10013 [City, State, Zip]

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations, 45 CFR § 164.508, YOU ARE HEREBY AUTHORIZED AND DIRECTED to furnish to JAMES E. JOHNSON, Corporation Counsel of the City of New York, attorney for the defendants in the above-captioned case, or to his authorized representative, a certified copy of all psychotherapy notes of XIAMIN ZENG (Date of Birth: 09/09/1981; SS #: 747-94-9901) who was examined or treated in your hospital or by you on or about generalized anxiety disorder.

The reason for this release of information is (a) at the request of individual, or (b) _____. This authorization will terminate upon the resolution of my lawsuit. The aforementioned expiration date has not passed as this matter is ongoing.

I have the right to revoke this authorization in writing by providing a signed, written notice of revocation to the health care provider listed above and to James E. Johnson, except to the extent that the provider listed above has taken action in reliance on this authorization. Medical providers may not condition treatment or payment on whether the above-listed patient executes this authorization. The information disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA).

Dated: New York, New York
7/8, 2020

XIAMIN ZENG

STATE OF NEW YORK)
: SS:
COUNTY OF Queens)

On the 8th day of July, 2020, before me personally came and appeared XIAMIN ZENG, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that she executed the same.

FUXIANG YE
Notary Public - State of New York
NO. 01YE6364486
Qualified in Queens County
My Commission Expires Sep 18, 2021

NOTARY PUBLIC

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
----------x

XIAMIN ZENG,

19-CV-3218 (JGK) (KHP)

Plaintiff,

-against-

RELEASE FOR PSYCHOTHERAPY NOTES

JOHN CHELL; GARY DENEZZO; GEORGE TAVAREZ; CITY OF NEW YORK; DIEGO ANDRIANZAN; DANIELLE FEBUS,

Defendants.
----------x

TO: John Chan, PhD. Psychologist [Health Care Provider]
17 Elizabeth St. # 409 [Address]
New York, NY 10013 [City, State, Zip]

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations, 45 CFR § 164.508, YOU ARE HEREBY AUTHORIZED AND DIRECTED to furnish to JAMES E. JOHNSON, Corporation Counsel of the City of New York, attorney for the defendants in the above-captioned case, or to his authorized representative, a certified copy of all psychotherapy notes of XIAMIN ZENG (Date of Birth: 09/09/1981; SS #: 747-94-9901) who was examined or treated in your hospital or by you on or about PTSD.

The reason for this release of information is (a) at the request of individual, or (b) _____. This authorization will terminate upon the resolution of my lawsuit. The aforementioned expiration date has not passed as this matter is ongoing.

I have the right to revoke this authorization in writing by providing a signed, written notice of revocation to the health care provider listed above and to James E. Johnson, except to the extent that the provider listed above has taken action in reliance on this authorization. Medical providers may not condition treatment or payment on whether the above-listed patient executes this authorization. The information disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA).

Dated: New York, New York
7/8, 2020

XIAMIN ZENG

STATE OF NEW YORK)
: SS:
COUNTY OF Queens)

On the 8th day of July, 2020, before me personally came and appeared XIAMIN ZENG, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that she executed the same.

FUXIANG YE
Notary Public – State of New York
NO. 01YE6364486
Qualified in Queens County
My Commission Expires Sep 18, 2021

NOTARY PUBLIC

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

----------x

XIAMIN ZENG,

Plaintiff,

-against-

JOHN CHELL; GARY DENEZZO; GEORGE TAVAREZ; CITY OF NEW YORK; DIEGO ANDRIANZAN; DANIELLE FEBUS,

Defendants.

----------x

MEDICARE RECORDS RELEASE

19-CV-3218 (JGK) (KHP)

TO: FOIA Service Center/FOIA Public Liaison
Centers for Medicare Services
26 Federal Plaza
New York, NY 10278

YOU ARE HEREBY AUTHORIZED and I hereby request you to furnish to JAMES E. JOHNSON, Corporation Counsel of the City of New York, attorney for the defendants in the above-captioned case, or to his authorized representative, a **CERTIFIED COPY** of the entire file of XIAMIN ZENG (Date of Birth: 09/09/81 ; SS #: 741-94-9901), who received Medicare benefits from February 2018 to present .

The Medicare file authorized for release includes, but is not limited to, any and all applications, determinations, correspondence, payments or credits made to such person.

The reason for this release of information is (a) at the request of individual, or (b) _____.

This Authorization will expire at the conclusion of the above-captioned litigation.

I understand that I have the right to revoke this authorization at any time. I must do so by writing to the same person(s) or class of persons that I directed this authorization to. The revocation will not apply to information that has already been released in response to this authorization.

I understand that my refusal to authorize disclosure of my personal medical information will have no effect on my enrollment, eligibility for benefits, or the amount Medicare pays for the health services I receive.

I understand that information disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by law.

Dated: New York, New York
7/8, 2020

XIAMIN ZENG

STATE OF NEW YORK)
: SS:
COUNTY OF Queens)

On the 8th day of July, 2020, before me personally came and appeared XIAMIN ZENG, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that she executed the same.

NOTARY PUBLIC

FUXIANG YE
Notary Public – State of New York
NO. 01YE6364486
Qualified in Queens County
My Commission Expires Sep 18, 2021

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH INSURANCE PROGRAMS
AUTHORIZATION TO RELEASE PROTECTED MEDICAID MEMBER INFORMATION TO A THIRD PARTY

Medicaid Member Name (required): XIAMIN ZENG

Date of Birth (required): 09 / 09 / 1981

At least one of the following identification numbers is required, preferably both.

Client Identification Number (CIN): 742115930 Social Security Number (SSN): 141 - 94 - 9901

Persons/organizations authorized to receive or use the information:

Name: Stephanie De Angelis

Address: 100 Church St

City: New York State: NY Zip: 10007

Phone Number: (212) 356-3513

Dates authorized: ☐ All OR From 03 / 01 / 2018 To ___ / ___ / ___ OR ☒ To Present

Purpose of the use/disclosure: Legal Matter

Will the person/program requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes X No ___

1. I understand that my health care and the payments for my health care will not be affected if I do not sign this form except in some situations when information is needed for the health plan's eligibility or enrollment determinations relating to the individual.

2. I understand, with few exceptions, that I may see and copy the information described on this form if I ask for it, and that I may get a copy of this form after I sign it.

3. I may revoke this authorization at any time by notifying the Department of Health in writing at the address below, but, if I do, it will not have any effect on actions that the Department took before they received the revocation. If not previously revoked, this authorization will expire upon completion of this request or one year from the date this form is signed, whichever comes first.

4. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan, health care provider or clearinghouse, the released information may no longer be protected by federal privacy regulations, and therefore the recipient of the confidential data may re-disclose the confidential data.

By signing this form I understand that I am allowing the New York State Department of Health to use or disclose all of the payment information for the Medical Member as indicated above, including data on certain conditions such as HIV/AIDS, Mental Health and Alcohol and Substance Abuse. I specially authorize release of such information to the person(s) indicated above as the recipient.

[signature] 7/8/20
Signature of Medicaid member of Agent — Date

If not member, name of person signing for member — Authority to sign on behalf of member

Witness Signature — Witness Name

Please return to:
Medical Data Warehouse - CDRs
NYSDOH - MISCNY
ESP P1-11S Dock J
Albany, New York 12237

ZACHARY W. CARTER
Corporation Counsel

The City of New York
LAW DEPARTMENT
100 CHURCH STREET
NEW YORK, N.Y. 10007

RITA SHAPSIS
Phone:(212) 356-3543
Fax: (212) 356-3509
rshapsis@law.nyc.gov

June 11, 2019

Edgar Mikel Rivera, Esq.
The Harman Firm, LLP
381 Park Avenue South
Ste 1220
New York, NY 10016

Re: Xiamin Zeng v. John Chell, et al.
19CV03218

Dear Mr. Rivera:

This office is in receipt of the complaint in the above-referenced action. The complaint alleges physical and/or emotional injuries as a result of the incident described in the complaint. In order for this lawsuit to proceed, the medical records pertaining to the incident described in the complaint must be available to defendants. Enclosed please find a medical release form.

Please have your client execute the release before a notary public and return the release to me within one week of the above date. **On the release, your client should provide the name and address of the medical provider, the date or dates of treatment, names or aliases used, the client's social security number and the client's date of birth. Also please have your client check off all of the boxes on the release.** The social security number and the date of birth are needed so that the medical provider can identify the proper records which concern plaintiff's treatment. Until the executed release is received by this office, we cannot secure the relevant medical records. Consequently, we will not be able to properly assess this case, or proceed to discovery. Your failure to promptly return this release will unduly delay this litigation. If you have any questions, please do not hesitate to call me.

Thank you for your attention to this matter.

Very truly yours,

Rita Shapsis
Paralegal
Special Federal Litigation Division

Enc.
cc: Stephanie De Angelis, Esq.
Assistant Corporation Counsel

D STATES DISTRICT COURT
ERN DISTRICT OF NEW YORK

----------x

AMIN ZENG,

Plaintiff,

-against-

JOHN CHELL, ET AL.,

Defendants

----------x

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

19CV03218 (JGK)

TO: Andrew Chan, MD, 17 Elizabeth St, #502, New York, NY 10013
NAME AND ADDRESS OF MEDICAL PROVIDER

I authorize the use and disclosure of XIAMIN ZENG'S health information as described below.

YOU ARE HEREBY AUTHORIZED to furnish to ZACHARY W. CARTER, Corporation Counsel of the City of New York, attorney for the defendants in the above-captioned case, or to his authorized representative, a **CERTIFIED COPY** of the entire medical or hospital record of XIAMIN ZENG (Date of Birth: 9/9/1981 ; SS #: 147-94-9901) who was examined or treated in your hospital or by you on or about April 2018.

The medical record authorized for release includes any and all x-rays of said person and any and all diagnostic tests, studies, or reports of examinations relating to such person.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol, and drug abuse.

This information may be disclosed to and used by the following organization:
The Office of the Corporation Counsel
100 Church Street
New York, NY 10007
for the purpose of defense of civil litigation

I understand I have the right to revoke this authorization at any time. In understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. Unless otherwise revoked, this authorization will expire on the following date, event or condition: Upon termination. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorization the disclosure of this health information is voluntary, I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact (Name of Medical Provider's Risk Management Office).

Dated: New York, New York
June 19, 2019

XIAMIN ZENG

STATE OF NEW YORK)
: SS:
COUNTY OF New York)

On the 19 day of June, 2019, before me personally came and appeared XIAMIN ZENG, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that she executed the same.

NOTARY PUBLIC

EDGAR M RIVERA
Notary Public - State of New York
NO. 02RI6331148
Qualified in New York County
My Commission Expires Oct 5, 2019

NYCHHC HIPAA Authorization to Disclose Health Information

ALL FIELDS MUST BE COMPLETED

THIS FORM MAY NOT BE USED FOR RESEARCH OR MARKETING, FUNDRAISING OR PUBLIC RELATIONS AUTHORIZATIONS

PATIENT NAME/ADDRESS	DATE OF BIRTH	PATIENT SSN
Xiamin Zeng 110 Columbia St. Apt 1A, New York, NY 10002	09/09/1981	747-94-9901
	MEDICAL RECORD NUMBER	TELEPHONE NUMBER
		929-250-4690

NAME OF HEALTH PROVIDER TO RELEASE INFORMATION	SPECIFIC INFORMATION TO BE RELEASED:
Andrew Chan, MD 17 Elizabeth St, #502 New York, NY 10013	Information Requested Treatment Dates from April 2018 to present
NAME & ADDRESS OF PERSON OR ENTITY TO WHOM INFO. WILL BE SENT Stephanie De Angelis, Esq. The Office of Corporate Counsel 100 Church St. New York, NY 10007	INFORMATION TO BE RELEASED (If the box is checked, you are authorizing the release of that type of information). Please note: unless all of the boxes are checked, we may be unable to process your request. ☒ Alcohol and/or Substance Abuse Program Information ☒ Mental Health Information ☒ Genetic Testing Information ☒ HIV/AIDS-related Information
REASON FOR RELEASE OF INFORMATION ☒ Legal Matter ☐ Individual's Request ☐ Other (please specify):	WHEN WILL THIS AUTHORIZATION EXPIRE? (Please check one) ☒ Event: upon exhaustion of appeals ☐ On this date:

I, or my authorized representative, authorize the use or disclosure of my medical and/or billing information as I have described on this form.

I understand that my medical and/or billing information could be re-disclosed and no longer protected by federal health information privacy regulations if the recipient(s) described on this form are not required by law to protect the privacy of the information.

I understand that if my medical and/or billing records contain information relating to **ALCOHOL** or **SUBSTANCE ABUSE, GENETIC TESTING, MENTAL HEALTH,** and/or **CONFIDENTIAL HIV/AIDS RELATED INFORMATION**, this information will not be released to the person(s) I have indicated unless I check the box(es) for this information on this form.

I understand that if I am authorizing the use or disclosure of HIV/AIDS-related information, the recipient(s) is prohibited from using or re-disclosing any HIV/AIDS-related information without my authorization, unless permitted to do so under federal or state law. I also understand that I have a right to request a list of people who may receive or use my HIV/AIDS-related information without authorization. If I experience discrimination because of the use or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 212.480.2493 or the New York City Commission of Human Rights at 212.306.7450. These agencies are responsible for protecting my rights.

I understand that I have a right to refuse to sign this authorization and that my health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form. I also understand that if I refuse to sign this authorization, NYCHHC cannot honor my request to disclose my medical and/or billing information.

I understand that I have a right to request to inspect and/or receive a copy of the information described on this authorization form by completing a Request for Access Form. I also understand that I have a right to receive a copy of this form after I have signed it.

I understand that if I have signed this authorization form to use or disclose my medical and/or billing information, I have the right to revoke it at any time, except to the extent that NYCHHC has already taken action based on my authorization or that the authorization was obtained as a condition for obtaining insurance coverage.

To revoke this authorization, please contact the facility Health Information Management department processing this request.

I have read this form and all of my questions have been answered. By signing below, I acknowledge that I have read and accept all of the above.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE	IF NOT PATIENT, PRINT NAME & CONTACT INFORMATION OF PERSONAL REPRESENTATIVE SIGNING FORM
DATE 06/19/2019	DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY TO ACT ON BEHALF OF PATIENT

If HHC has requested this authorization, the patient or his/her Personal Representative must be provided a copy of this form after it has been signed.

HHC USE ONLY	
Date Received:	Initials of HIM employee processing request:
Date Completed:	Comments:

NYCHHC HIPAA Authorization 2413. Revised 06-05

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
XIAMIN ZENG	9/9/81	147-94-9901
Patient Address: 110 Columbia St. Apt 1A New York, NY 10002		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Andrew Chan, MD, 17 Elizabeth St. #502, New York, NY 10013

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis, Esq., 100 Church Street, New York, NY 10007

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

- XZ **Alcohol/Drug Treatment**
- XZ **Mental Health Information**
- XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider)

to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: **litigation**	**upon the exhaustion of appeals**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 6/19/19

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name XIAMIN ZENG	Date of Birth 9/9/81	Social Security Number 747-94-9901
Patient Address 110 Columbia St. Apt. 1A New York, NY 10002		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Chun-Kit Chan, MD, CKC Medical Office 2 Mott St. #305, New York, NY 10013

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis, Esq. 100 Church Street, New York, NY 10007

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

- XZ **Alcohol/Drug Treatment**
- XZ **Mental Health Information**
- XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: **litigation**	**upon the exhaustion of appeals**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 6/19/19

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name XIAMIN ZENG	Date of Birth 9/9/81	Social Security Number 747-94-9901
Patient Address 110 Columbia St Apt 1A New York, NY 10002		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Tak W. Kwan, MD, 139 Centre St, #307, New York, NY 10013

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis, Esq. 100 Church Street, New York, NY 10007

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

- XZ **Alcohol/Drug Treatment**
- XZ **Mental Health Information**
- XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☑ Other: **litigation**	11. Date or event on which this authorization will expire: **upon the exhaustion of appeals**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 6/19/19

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
XIAMIN ZENG	9/9/81	747-94-9901
Patient Address: 110 Columbia St Apt 1A New York, NY 10002		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Jing Guo, LAD, 217 Grand St, Ste 6, New York, NY 10013

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis, Esq., 100 Church Street, New York, NY 10007

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

- XZ **Alcohol/Drug Treatment**
- XZ **Mental Health Information**
- XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: **litigation**	**upon the exhaustion of appeals**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 6/19/19

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
XIAMIN ZENG	9/9/81	747-94-9901
Patient Address: 110 Columbia St Apt 1A New York, NY 10002		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Kathy Feng, AUD, 128 Mott St. #509, New York, NY 10013

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis, Esq. 100 Church Street, New York, NY 10007

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

- XZ **Alcohol/Drug Treatment**
- XZ **Mental Health Information**
- XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: **litigation**	**upon the exhaustion of appeals**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 6/19/19

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
XIAMIN ZENG	9/9/81	747-94-9901
Patient Address: 110 Columbia St Apt 1A New York, NY 10002		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Norman Chan, MD, 202 Canal St. #602, New York, NY 10013

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis, Esq, 100 Church Street, New York, NY 10007

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

- XZ **Alcohol/Drug Treatment**
- XZ **Mental Health Information**
- XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: **litigation**	**upon the exhaustion of appeals**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 6/19/19

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
XIAMIN ZENG	9/9/81	747-94-9901
Patient Address: 110 Columbia St Apt 1A New York, NY 10002		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Haochen Wei, MD, 139 Centre St #215, New York, NY 10013

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis, Esq. 100 Church Street, New York, NY 10007

9(a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

Include: (*Indicate by Initialing*)

XZ **Alcohol/Drug Treatment**

XZ **Mental Health Information**

XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: **litigation**	**upon the exhaustion of appeals**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 6/19/19

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name XIAMIN ZENG	Date of Birth 9/9/81	Social Security Number 747-94-9901
Patient Address 110 Columbia St Apt 1A New York, NY 10002		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
New York-Presbyterian/Lower Manhattan Hospital Emergency Department, 170 William St, New York NY 10038

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie DeAngelis, Esq. 100 Church Street, New York, NY 10007

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

- XZ **Alcohol/Drug Treatment**
- XZ **Mental Health Information**
- XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: **litigation**	**upon the exhaustion of appeals**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 6/19/19

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
XIAMIN ZENG	09/09/81	147-94-9901

Patient Address: 110 Columbia St, Apt 1A New York NY 10002

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Mount Sinai Beth Israel Emergency Room, 281 1st Ave, New York, NY 10003

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis, Esq., 100 Church Street, New York, NY 10007

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

- XZ **Alcohol/Drug Treatment**
- XZ **Mental Health Information**
- XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: **litigation**	**upon the exhaustion of appeals**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 6/19/19

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
XIAMIN ZENG	9/9/81	747-94-9901
Patient Address: 110 Columbia St, Apt 1A New York, NY 10002		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
John Chan, PhD, 17 Elizabeth St, #409, New York, NY 10013

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis, Esq, 100 Church Street, New York, NY, 10007

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

- XZ **Alcohol/Drug Treatment**
- XZ **Mental Health Information**
- XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: **litigation**	**upon the exhaustion of appeals**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 6/19/19

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
XIAMIN ZENG	9/9/81	747-94-9901

Patient Address: 110 Columbia St. Apt 1A New York, NY 10002

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
University Settlement Care Coordination Services, 184 Eldridge St, New York, NY 10002

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis, Esq., 100 Church Street, New York, NY 10007

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

- XZ **Alcohol/Drug Treatment**
- XZ **Mental Health Information**
- XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: **litigation**	**upon the exhaustion of appeals**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 6/19/19

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Form **1040** Department of the Treasury—Internal Revenue Service (99) **U.S. Individual Income Tax Return** **2018** OMB No. 1545-0074 IRS Use Only–Do not write or staple in this space.

Filing status: ☐ Single ☐ Married filing jointly ☐ Married filing separately ☒ Head of household ☐ Qualifying widow(er)

Your first name and initial	Last name	Your social security number
XIAMIN	ZENG	747-94-9901

Your standard deduction: ☐ Someone can claim you as a dependent ☐ You were born before January 2, 1954 ☐ You are blind

If joint return, spouse's first name and initial	Last name	Spouse's social security number

Spouse standard deduction: ☐ Someone can claim your spouse as a dependent ☐ Spouse was born before January 2, 1954 ☐ Spouse is blind ☐ Spouse itemizes on a separate return or you were a dual-status alien

☒ Full-year health care coverage or exempt (see instr.)

Home address (number and street). If you have a P.O. box, see instructions. Apt. no.
110 COLUMBIA STREET #1A

Presidential Election Campaign (see instr.) ☐ You ☐ Spouse

City, town or post office, state, and ZIP code. If you have a foreign address, attach Schedule 6.
NEW YORK NY 10002

If more than four dependents, see instr. and ✓ here ▶ ☐

Dependents (see instructions): (1) First name / Last name	(2) Social security number	(3) Relationship to you	(4) ✓ if qualifies for (see instr.) Child tax credit	Credit for other dependents
LONGMAN LIU	882-60-7907	Son	☒	☐
			☐	☐
			☐	☐
			☐	☐

Sign Here Under penalties of perjury, I declare that I have examined this return and accompanying schedules and statements, and to the best of my knowledge and belief, they are true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Joint return? See instructions. Keep a copy for your records.

Your signature	Date	Your occupation	If the IRS sent you an Identity Protection PIN, enter it here (see instr.)
Spouse's signature. If a joint return, **both** must sign.	Date	Spouse's occupation	If the IRS sent you an Identity Protection PIN, enter it here (see instr.)

Paid Preparer Use Only

Preparer's name	Preparer's signature	PTIN	Check if:
EVA CEN EA	EVA CEN EA	P00744121	☐ 3rd Party Designee
Firm's name ▶ KAFFCO & COMPANY, INC.		Firm's EIN 13-3962257	☐ Self-employed
Firm's address ▶ 128 Mott St Ste 508 New York NY 10013-5575		Phone no. 212-965-1968	

For Disclosure, Privacy Act, and Paperwork Reduction Act Notice, see separate instructions. Form **1040** (2018)

DAA

Form 1040 (2018) XIAMIN ZENG 747-94-9901 Page 2

	1	Wages, salaries, tips, etc. Attach Form(s) W-2				1	
	2a	Tax-exempt interest	2a		b Taxable interest	2b	
	3a	Qualified dividends	3a		b Ordinary dividends	3b	
	4a	IRAs, pensions, and annuities	4a		b Taxable amount	4b	
Attach Form(s) W-2. Also attach Form(s) W-2G and 1099-R if tax was withheld.	5a	Social security benefits	5a		b Taxable amount	5b	
	6	Total income. Add lines 1 through 5. Add any amount from Schedule 1, line 22				6	0
	7	Adjusted gross income. If you have no adjustments to income, enter the amount from line 6; otherwise subtract Schedule 1, line 36, from line 6				7	0
Standard Deduction for – • Single or married filing separately, $12,000 • Married filing jointly or Qualifying widow(er), $24,000 • Head of household, $18,000 • If you checked any box under Standard deduction, see instructions.	8	**Standard deduction or itemized deductions** (from Schedule A)				8	18,000
	9	Qualified business income deduction (see instructions)				9	
	10	Taxable income. Subtract lines 8 and 9 from line 7. If zero or less, enter -0-				10	0
	11	a Tax (see instr.) 0 (check if any from: 1 ☐ Form(s) 8814 2 ☐ Form 4972 3 ☐)					
		b Add any amount from Schedule 2 and check here ▶ ☐				11	0
	12	a Child tax credit/credit for other dependents			b **Add** any amount from Schedule 3 and check here ▶ ☐	12	
	13	Subtract line 12 from line 11. If zero or less, enter -0-				13	0
	14	Other taxes. Attach Schedule 4				14	
	15	Total tax. Add lines 13 and 14				15	0
	16	Federal income tax withheld from Forms W-2 and 1099				16	
	17	Refundable credits: a EIC (see instr.)			b Sch 8812		
		c Form 8863					
		Add any amount from Schedule 5				17	
	18	Add lines 16 and 17. These are your total payments				18	
	19	If line 18 is more than line 15, subtract line 15 from line 18. This is the amount you **overpaid**				19	
Refund	20a	Amount of line 19 you want **refunded to you.** If Form 8888 is attached, check here ▶ ☐				20a	
Direct deposit? See instructions.	▶ b	Routing number		▶ c Type: ☐ Checking ☐ Savings			
	▶ d	Account number					
	21	Amount of line 19 you want **applied to your 2019 estimated tax** ▶	21				
Amount You Owe	22	**Amount you owe.** Subtract line 18 from line 15. For details on how to pay, see instructions ▶				22	0
	23	Estimated tax penalty (see instructions) ▶	23				

Go to *www.irs.gov/Form1040* for instructions and the latest information. Form **1040** (2018)

DAA

Form **1040** Department of the Treasury—Internal Revenue Service (99) **U.S. Individual Income Tax Return** **2019** OMB No. 1545-0074 IRS Use Only–Do not write or staple in this space.

Filing Status Check only one box. [X] Single [ ] Married filing jointly [ ] Married filing separately (MFS) [ ] Head of household (HOH) [ ] Qualifying widow(er) (QW)
If you checked the MFS box, enter the name of spouse. If you checked the HOH or QW box, enter the child's name if the qualifying person is a child but not your dependent.

Your first name and middle initial	Last name	Your social security number
XIAMIN	ZENG	747-94-9901
If joint return, spouse's first name and middle initial	Last name	Spouse's social security number

Home address (number and street). If you have a P.O box, see instructions. Apt. no.
110 COLUMBIA STREET #1A

City, town or post office, state, and ZIP code. If you have a foreign address, also complete spaces below (see instructions).
NEW YORK NY 10002

Foreign country name | Foreign province/state/county | Foreign postal code | If more than four dependents, see instr. and ✓ here ▶ [ ]

Presidential Election Campaign Check here if you, or your spouse if filing jointly, want $3 to go to this fund. Checking a box below will not change your tax or refund. [ ] You [ ] Spouse

Standard Deduction **Someone can claim:** [ ] You as a dependent [ ] Your spouse as a dependent
[ ] Spouse itemizes on a separate return or you were a dual-status alien

Age/Blindness **You:** [ ] Were born before January 2, 1955 [ ] Are blind **Spouse:** [ ] Was born before January 2, 1955 [ ] Is blind

Dependents (see instructions):

(1) First name / Last name	(2) Social security number	(3) Relationship to you	(4) ✓ if qualifies for (see instructions): Child tax credit	Credit for other dependents

1	Wages, salaries, tips, etc. Attach Form(s) W-2			1	
2a	Tax-exempt interest	2a	b Taxable interest. Attach Sch. B if required	2b	
3a	Qualified dividends	3a	b Ordinary divs. Att. Sch. B if req.	3b	
4a	IRA distributions	4a	b Taxable amount	4b	
c	Pensions and annuities	4c	d Taxable amount	4d	
5a	Soc. sec. ben.	5a	b Taxable amount	5b	
6	Capital gain or (loss). Attach Schedule D if required. If not required, check here ▶ [ ]			6	
7a	Other income from Schedule 1, line 9			7a	0
b	Add lines 1, 2b, 3b, 4b, 4d, 5b, 6, and 7a. This is your **total income** ▶			7b	0
8a	Adjustments to income from Schedule 1, line 22			8a	0
b	Subtract line 8a from line 7b. This is your **adjusted gross income** ▶			8b	0
9	**Standard deduction or itemized deductions** (from Schedule A)		9 12,200		
10	Qualified business income deduction. Attach Form 8995 or Form 8995-A		10		
11a	Add lines 9 and 10			11a	12,200
b	**Taxable income.** Subtract line 11a from line 8b. If zero or less, enter -0-			11b	0

Standard Deduction for
- Single or Married filing separately, $12,200
- Married filing jointly or Qualifying widow(er), $24,400
- Head of household, $18,350
- If you checked any box under *Standard Deduction*, see instructions.

For Disclosure, Privacy Act, and Paperwork Reduction Act Notice, see separate instructions. Form **1040** (2019)

DAA

Form 1040 (2019) XIAMIN ZENG 747-94-9901 Page 2

	12a	**Tax** (see instr.) Check if any from Form(s): 1 ☐ 8814 2 ☐ 4972 3 ☐	12a 0	
	b	Add Schedule 2, line 3, and line 12a and enter the total ▶	12b	0
	13a	Child tax credit or credit for other dependents 13a -		
	b	Add Schedule 3, line 7, and line 13a and enter the total ▶	13b	
	14	Subtract line 13b from line 12b. If zero or less, enter -0-	14	0
	15	Other taxes, including self-employment tax, from Schedule 2, line 10	15	
	16	Add lines 14 and 15. This is your **total tax** ▶	16	0
	17	Federal income tax withheld from Forms W-2 and 1099	17	
• If you have a qualifying child, attach Sch. EIC. • If you have nontaxable combat pay, see instructions.	18	Other payments and refundable credits:		
	a	Earned income credit (EIC) 18a		
	b	Additional child tax credit. Attach Schedule 8812 18b		
	c	American opportunity credit from Form 8863, line 8 18c		
	d	Schedule 3, line 14 18d		
	e	Add lines 18a through 18d. These are your **total other payments and refundable credits** ▶	18e	
	19	Add lines 17 and 18e. These are your **total payments** ▶	19	
Refund	20	If line 19 is more than line 16, subtract line 16 from line 19. This is the amount you **overpaid**	20	
	21a	Amount of line 20 you want **refunded to you.** If Form 8888 is attached, check here ▶ ☐	21a	
Direct deposit? See instructions.	▶b	Routing number ▶c Type: ☐ Checking ☐ Savings		
	▶d	Account number		
	22	Amount of line 20 you want **applied to your 2020 estimated tax** ▶ 22		
Amount You Owe	23	**Amount you owe.** Subtract line 19 from line 16. For details on how to pay, see instructions ▶	23	0
	24	Estimated tax penalty (see instructions) ▶ 24		

Third Party Designee Do you want to allow another person (other than your paid preparer) to discuss this return with the IRS? See instructions ☐ **Yes.** Complete below. ☐ **No**

(Other than paid preparer) Designee's name ▶ Phone no. ▶ Personal identification number (PIN) ▶

Sign Here Under penalties of perjury, I declare that I have examined this return and accompanying schedules and statements, and to the best of my knowledge and belief, they are true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Joint return? See instructions. Keep a copy for your records.

Your signature	Date	Your occupation	If the IRS sent you an Identity Protection PIN, enter it here (see instr.)
Spouse's signature. If a joint return, **both** must sign.	Date	Spouse's occupation	If the IRS sent your spouse an Identity Protection PIN, enter it here (see instr.)

Phone no. Email address

Paid Preparer Use Only

Preparer's name	Preparer's signature	PTIN	Check if:
EVA CEN EA	EVA CEN EA	P00744121	☐ 3rd Party Designee
Firm's name ▶ KAFFCO & COMPANY, INC.		Date 02/22/20	☐ Self-employed
Firm's address ▶ 128 Mott St Ste 508 New York NY 10013-5575		Phone no. 212-965-1968	Firm's EIN ▶ 13-3962257

Go to *www.irs.gov/Form1040* for instructions and the latest information. Form **1040** (2019)

DAA

DESIGNATION OF AGENT FOR ACCESS TO RECORDS SEALED PURSUANT TO NYCPL §§ 160.50 AND 160.55

I, Xiamin Zeng, Date of Birth 09/09/1981, SS# 747-94-9901, NYSID # 2018KN005716 pursuant to CPL §§ 160.50 and 160.55, hereby designate JAMES E. JOHNSON, Corporation Counsel of the City of New York, or his authorized representative, as my agent to whom all records of any of my arrests may be made available.

I understand that until now the aforesaid records have been sealed pursuant to CPL §§ 160.50 and 160.55, which permits those records to be made available only (1) to persons designated by me, or (2) to certain other parties specifically designated in that statute.

I further understand that the person designated by me above as a person to whom the records may be made available is not bound by the statutory sealing requirements of CPL § 160.50 and 160.55.

The records to be made available to the person designated above comprise all records and papers relating to any and all of my arrests on file with any court, police agency, prosecutor's office or state or local agency that were ordered to be sealed under the provisions of CPL §§ 160.50 and 160.55.

Signature

XIAMIN ZENG
Xiamin Zeng

STATE OF NEW YORK)
: SS.:
COUNTY OF Queens)

On the 8th day of July, 2020, before me personally came Xiamin Zeng, to me known and known to me to be the individual described in and who executed the foregoing instrument, and she acknowledged to me that she executed the same.

NOTARY PUBLIC

FUXIANG YE
Notary Public – State of New York
NO. 01YE6364486
Qualified in Queens County
My Commission Expires Sep 18, 2021

DESIGNATION OF AGENT FOR ACCESS TO SEALED RECORDS PURSUANT TO FAMILY COURT ACT § 375.1

I, XIAMIN ZENG, pursuant to FCA § 375.1, hereby designate JAMES E. JOHNSON, Corporation Counsel of the City of New York, or his authorized representative, as my agent to whom a CERTIFIED COPY of the records of the criminal action, terminated in my favor, entitled In the Matter of 1983 v. Prisoner Civil Right, Docket No. NN-02222-18, in Family Court, County of New York, State of New York, relating to my arrest on or about 19-CV-3218, may be made available for photocopying and use in a federal action brought by myself.

I understand that until now the aforesaid records have been sealed pursuant to FCA § 375.1, which permits those records to be made available only (1) to persons designated by me, or (2) to certain other parties specifically designated in that statute.

I further understand that the person designated by me above as a person to whom the records may be made available is not bound by the statutory sealing requirements of FCA § 375.1.

The records to be made available to the person designated above comprise all records and papers relating to my arrest and prosecution in the criminal action identified herein on file with any court, police agency, prosecutor's office or state or local agency that were ordered to be sealed under the provisions of FCA § 375.1

XIAMIN ZENG

STATE OF NEW YORK)
: SS.:
COUNTY OF Queens)

On this 8th day of July, 2020, before me personally came XIAMIN ZENG, to me known and known to me to be the individual described in and who executed the foregoing instrument, and she acknowledged to me that she executed the same.

NOTARY PUBLIC

FUXIANG YE
Notary Public - State of New York
NO. 01YE6364486
Qualified in Queens County
My Commission Expires Sep 18, 2021

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
----------x

XIAMIN ZENG,

Plaintiff,

-against-

JOHN CHELL; GARY DENEZZO; GEORGE TAVAREZ; CITY OF NEW YORK; DIEGO ANDRIANZAN; DANIELLE FEBUS,

Defendants.
----------x

RELEASE FOR EMPLOYMENT RECORDS

19-CV-3218 (JGK) (KHP)

TO: NYC Housing Auth. 90 church St. 6th Floor New York, NY 10007
NAME AND ADDRESS OF EMPLOYER

YOU ARE HEREBY AUTHORIZED to furnish to JAMES E. JOHNSON, Corporation Counsel of the City of New York, attorney for the defendants in the above-captioned case, or to his authorized representative, a **CERTIFIED COPY** of the entire employment record, including but not limited to she application, attendance records, disciplinary records, performance evaluations, workers' compensation records, medical records/nurses records, and/or any doctors notes, and psychiatric/psychological records of XIAMIN ZENG (Date of Birth: 09/09/81; SS #: 747-94-9901), employed by you from 7/15/2016 until 5/16/2017.

Dated: New York, New York
7/8, 2020

XIAMIN ZENG

STATE OF NEW YORK)
: SS:
COUNTY OF Queens)

On the 8th day of July, 2020, before me personally came and appeared XIAMIN ZENG, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that she executed the same.

NOTARY PUBLIC

FUXIANG YE
Notary Public - State of New York
NO. 01YE6364486
Qualified in Queens County
My Commission Expires Sep 18, 2021

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

XIAMIN ZENG,

Plaintiff,

vs.

JOHN CHELL et al

Defendants.

RESPONSES TO INTERROGATORIES AND REQUESTS FOR DOCUMENTS PURSUANT TO FEDERAL RULE OF CIVIL PROCEDURE 33 AND 34

19-CV-3218 (JGK) (KHP)

Pursuant to Rules 26 and 34 of the Federal Rules of Civil Procedure, Plaintiff, Xiamin Zeng (Plaintiff'), submits the following objections and responses to Defendant's First Set of Interrogatories dated June 26, 2020 ("Interrogatories").

Plaintiff's responses to the Requests reflect Plaintiff's best knowledge after a reasonable search at this point in the litigation. Plaintiff expressly reserves the right to supplement, modify, or add to her responses to the Requests based on her ongoing inquiries.

I, Xiamin Zeng, pursuant to 28 U.S.C. § 1746, hereby declare under penalty of perjury that the following is true and correct:

INTERROGATORIES

1. **Identify all persons who witnessed, were present at, or have knowledge of the Incident, including the home and business addresses and telephone numbers of each witness. If you are unable to identify any of the individuals within the meaning of Local Rule 26.3, describe that individual's physical appearance.**

    1. Plaintiff objects to this interrogatory because it's overly broad.
        a. Subject to and without waiving these objections, Plaintiff responds as follows:

Jacob Gerber Esq. T: 212-556-2186; Kayla Green Esq. T: 212-556-2225 King & Spalding LLP, 1185 Ave of the Americas, New York, NY 100036

Linda S Povman Esq. T: 718-899-6848, 12335 82nd Rd Kew Gardens, NY 11415

Tosha Y Foster Esq. T: 718-544-3499, The Children's Law Center 11821 Queens Blvd Ste 417 Forest Hills, NY, 11375

Jonathan FBI at New York, T: 212-384-2249, 26 Federal Plaza 23 Floor New York, NY, 10278 Neighbors Apt. 1B-1D, 2A-2C, 110-120 Columbia Street, New York, NY 10002

2. Identify any and all statements, signed or unsigned, recorded electronically or otherwise, prepared by plaintiff or any other person that relate to the claims and/or subject matter of this litigation.

2. Plaintiff objects to this interrogatory because it's overly broad.

a. Subject to and without waiving these objections, Plaintiff responds as follows:

On 1/31/2018, Plaintiff received a text message from Detective Danielle Febus saying her son was in custody at the Queens Child Abuse Squad that she needed to pick him up.
On 1/25/2018, Linda Povman Esq. emailed Plaintiff about Plaintiff's 17-cv-9988 federal complaint against them.
On 04/2018 Plaintiff have a recording obtained from Evelyn Alexander Social worker from University Settlement Society, which is about ACS/CPS and NYPD's harassment against the plaintiff and her son.

3. Identify any and all statements, signed or unsigned, recorded electronically or otherwise, prepared by the City of New York, or its agents, servants and/or employees, that relate to the claims and/or subject matter of this litigation.

3. Plaintiff objects to this interrogatory because it seeks information not within Plaintiff's control.

4. Identify all injuries claimed by plaintiff as a result of the Incident and the medical, psychiatric, psychological, and other treatment provided, if any. For each such treatment received, identify the provider who rendered the treatment to plaintiff. If no treatment was provided for any claimed injury, so state.

4. Plaintiff objects to this interrogatory because it's already provided as part of Rule 26 disclosures.

a. Subject to and without waiving these objections, Plaintiff responds as follows:

Evelyn Alexander, Social Services, University Settlement Society for Mental Health
184 Eldridge St, New York, NY 10002 T: 212-674-9120 F: 212-475-3278
Andrew Chan, MD, Psychiatrist for generalized anxiety disorder and major depression
17 Elizabeth St # 502, New York, NY 10013 T: 212-431-9884
John Chan, PhD Psychologist for PTSD
17 Elizabeth St # 409, New York, NY 10013 T: 212-223-2223 F: 212-233-2223
Mount Sinai Beth Israel Emergency Room for dizziness, shortness of breath and nausea.
281 1st Ave, New York, NY 10003 T: 212-844-1644
New York Presbyterian/Lower Manhattan Hospital Emergency Department for dizziness, shortness of breath and nausea.
170 William St, New York, NY10038 T: 212-312-5070
Huachen Wei, MD, Dermatologist for hair loss and dermatitis
139 Centre St #215, New York, NY 10013 T: 212-343-1257
Norman Chan, MD, Otolaryngologist for hearing loss and dizziness
202 Canal St #602, New York, NY 10013 T: 917-261-2718 F: 917-261-2719
Kathy Feng, MD, Audiologist. New York Hearing Center for hearing loss and hearing aid
128 Mott St #509, New York, NY 10013 T: 212-966-3886
Jing Guo, MD, Audiologist. Oriental K Audiology for dizziness and hearing loss
217 Grand St, Ste 6, New York, NY 10013 T: 646-422-7562 F: 212-431-8246
Jeffrey Chan, Jeffrey Chan Acupuncture Clinic for physical therapy on neck back arms and legs
107 E Broadway 3Fl, New York, NY 10002 T: 646 354-8828

5. Identify all economic injuries claimed by plaintiff as a result of the Incident including, but not limited to, expenditures for medical, psychiatric, or psychological treatment; lost income; property damage; and attorney's fees. Identify the specific amounts claimed for each injury.

5. Plaintiff objects to this interrogatory because it's overly broad and duplicative.

a. Subject to and without waiving these objections, Plaintiff responds as follows:

A. Loss of Liberty Damages

Plaintiff suffers loss of liberty damages. Loss of liberty for false arrest claims in 2019 varies between $13,000 and $394,000. *See Martinez v. Port Auth. of N.Y. & N.J.*, No. 01 CIV. 721 (PKC), 2005 WL 2143333, at *22 (S.D.N.Y. Sept. 2, 2005), *aff'd sub nom. Martinez v. The Port Auth. of New York & New Jersey*, 445 F.3d 158 (2d Cir. 2006) (stating that false arrest awards vary between $10,000 and $300,000 adjusted for inflation for 2005); *Gardner v. Federated Dep't Stores, Inc.*, 907 F.2d 1348, 1353 (2d Cir. 1990) (ordering the remittitur of a $300,000 jury award to $200,000 (roughly $344,000 in 2019 dollars) for approximately 8 hours of imprisonment); *Stile v. City of New York*, 172 A.D.2d 743 (2d Dep't 1991) (ordering a remittitur amount of $150,000 [roughly $381,000 in 2019 dollars] for 28 hours of imprisonment).The NYPD held Ms. Zeng approximately 26 hours and handcuffed her for over an hour. During her incarceration, she did not know where her child was. As such, she could expect a significant award for loss of liberty damages.

B. Emotional Distress Damages

Plaintiff seeks loss of emotional distress damages. Courts have given substantial awards for emotional distress resulting from false arrest. *Gonzalez v. Bratton*, 147 F.Supp.2d 180, 208–09 (S.D.N.Y.2001) (upholding a compensatory award of $250,000 for emotional distress resulting from a false arrest that included a physically invasive search). In *Martinez v. Port Auth. of N.Y. & N.J.*, the Court found that, even though plaintiff was not subject to physical assault by an officer, he still experienced considerable anguish due to his arrest, which included sleeplessness, loss of appetite, anxiety bouts, cessation of social, volunteer, and church activities, ideations of suicide, and concerns about his immigration status. 2005 WL 2143333, at *21. The court held that "an award of $200,000 [in 2005] does not shock the judicial conscience." *Id.* This would be $262,000 in 2019.

As a result of her arrest, Plaintiff was diagnosed with generalized anxiety disorder and major depressive disorder. Her emotional distress is ongoing. In light of the relevant case law, Plaintiff could expect a significant award for emotional distress damages. Plaintiff made a demand of $500,000

6. Identify all of plaintiff's employers for the past ten (10) years, including the name, telephone number and address of each employer and the dates of each employment.

6. Plaintiff objects to this interrogatory because it's disproportionate to the needs of the case and would like to limit the scope of the interrogatory to the past 4 years.

   a. Subject to and without waiving these objections, Plaintiff responds as

follows:

7/15/2016-5/15/2017 NYC Housing Auth, 90 Church St 6th Floor, New York, NY 10007 212-306-3000

7. Identify all medical providers including, but not limited to, doctors, hospitals, psychiatrists, psychologists, social workers and other counseling services, who have rendered treatment to the plaintiff within the past ten (10) years.

7. Plaintiff objects to this interrogatory because it's disproportionate to the needs of the case and duplicative.

   a. Subject to and without waiving these objections, Plaintiff responds as follows:

   See response to Interrogatory 4

8. Has plaintiff applied for worker's compensation within the past ten (10) years? If so, identify each employer who provided worker's compensation to plaintiff.

8. Plaintiff responds as follows:

   None

9. Has plaintiff applied for social security disability benefits within the past ten (10) years? If so, identify each state, city, or other jurisdiction that provided social security disability benefits to plaintiff.

9. Plaintiff responds as follows:

   None

10. Has plaintiff applied for Medicare and/or Medicaid within the past ten (10) years? If so, identify each state, city or other jurisdiction that provided Medicare and/or Medicaid to plaintiff.

10. Plaintiff responds as follows:

    Yes, Medicaid: NN11415T; New York State of Health.

11. Has plaintiff made a claim with any insurance carrier for physical, mental or emotional injuries within the past ten (10) years? If so, identify each claim by date, injury and insurance carrier.

11. Subject to and without waiving these objections, Plaintiff responds as follows:

Medicaid NN11415T, Fidelis Care 742115930 and Healthfirst NN11415T covered up (Medical cost was covered by Medicaid after 03/01/2018 except out-of-pocket expenses due to temporary suspense of her Medicaid)
Evelyn Alexander, University Settlement Society for mental health and social services from April, 2018 - Present Medicaid
Andrew Chan, MD, Psychiatrist for generalized anxiety disorder and major depression from May, 2018 - Present Fidelis
John Chan, PhD, Psychologist for PTSD from May, 2018 - Present Fidelis
Mount Sinai Beth Israel Emergency Room for dizziness, shortness of breath, nausea from September, 2018 - Present Medicaid
New York Presbyterian/Lower Manhattan Hospital Emergency Department for dizziness and shortness of breath from September, 2018 - Present Medicaid
Huachen Wei, MD, Dermatologist for hair loss and dermatitis from February, 2019-Present Fidelis
Norman Chan, MD, Otolaryngologist for hearing loss and dizziness from January, 2019 - Present Fidelis
Kathy Feng Audiologist. New York Hearing Center for hearing loss and hearing aid from January, 2019 – Present Healthfirst
Jing Guo, Audiologist. Oriental K Audiology for dizziness and hearing loss from February, 2019 – Present Fidelis
Chan Jeffrey Acupuncture Clinic for physical therapy on neck back legs from June, 2019 –Present Fidelis

12. Identify all government agencies to whom plaintiff made complaints regarding the Incident including, but not limited to, the Civilian Complaint Review Board ("CCRB") and the Internal Affairs Bureau ("IAB") of the New York City Police Department.

12. Plaintiff objects to this interrogatory because it's overly broad.

a. Subject to and without waiving these objections, Plaintiff responds as follows:

NYC Comptroller, NYC Public Advocate, DOJ Office for Victims of Crime, FBI and Congresswoman Nydia Velazquez et al.

13. Identify each occasion on which plaintiff has been arrested other than the Incident that is the subject of this lawsuit, including the date of the arrest, the charges for which the plaintiff was arrested, and the amount of time that plaintiff spent incarcerated.

13. Plaintiff objects to this interrogatory because it's disproportionate to the needs of this case.

a. Subject to and without waiving these objections, Plaintiff responds as follows:

On 5/3-5/4/2017, ACS claimed that plaintiff violated ACS's order.
On 1/24-1/31/2019, ACS claimed that plaintiff violated ACS's order.
On 3/4-3/5/2019, ACS claimed that plaintiff violated ACS's order again.

14. Identify each occasion in which plaintiff has been convicted of a felony or misdemeanor, including the date of the conviction, the charges of which plaintiff was convicted, and amount of time that plaintiff spent incarcerated as a result of each conviction.

14. Plaintiff responds as follows:

None

15. Identify each lawsuit to which plaintiff has been a party, including the court in which the matter was pending, the docket or index number, and the disposition of the matter.

15. Plaintiff objects to this interrogatory because it's overly broad.

a. Subject to and without waiving these objections, Plaintiff responds as follows:

Zeng v. Chell, 19 –CV-3218 (pending); Zeng v. City, 20-CV-0451 (pending);
Zeng v. NYCHA, 18-CV-12008 (pending); Zeng v. Augustin, 17-cv-9988 (dismissed);
ACS v. Zeng, NN-02222-18 (dismissed); ACS v. Zeng, NN-00114-18/19A (dismissed);
Zeng v. Liu, F-35118-16/17A (Zeng won); Zeng v. Liu, V-00005-14 (Zeng won).

16. Identify each occasion on which plaintiff has given testimony or statements regarding the subject of this lawsuit.

16. Plaintiff objects to this interrogatory because it's vague and ambiguous.

a. Subject to and without waiving these objections, Plaintiff responds as follows:

Depositions requested by the defendant for her 17-cv-9988 case.

17. Identify all treating physicians and other medical providers that plaintiff intends to call at the time of trial.

17. Plaintiff objects to this interrogatory because it is premature and further discovery is needed for answering this interrogatory.

a. Subject to and without waiving these objections, Plaintiff responds as follows:

Andrew Chan, MD, Psychiatrist 17 Elizabeth St # 502, New York, NY 10013
John Chan, PhD Psychologist 17 Elizabeth St # 409, New York, NY 10013
Evelyn Alexander, Social Services, University Settlement184 Eldridge St, New York, NY 10002

18. Identify all experts that plaintiff expects to call at the time of trial, all correspondence between counsel for plaintiff and any such experts, any notes taken by any such experts and provide all disclosures required pursuant to Federal Rule 26(a)(2).

18. Plaintiff objects to this interrogatory because it is premature and further discovery is needed for answering this interrogatory.

19. Identify all documents prepared by plaintiff, or any other person that relate to the Incident, claims and subject matter of this litigation.

19. Plaintiff objects to this interrogatory because it is overly broad and duplicative.

20. Identify all Freedom of Information Law requests and any responses thereto, made by plaintiff or by anyone on plaintiff's behalf, concerning plaintiff's claims in this litigation.

20. Plaintiff responds as follows:

None

DOCUMENT REQUESTS

1. Produce all the documents identified in the preceding Interrogatories.

1. Plaintiff objects to this interrogatory because it is overly broad and duplicative.

a. Subject to and without waiving these objections, Plaintiff directs defendant to documents attached.

2. Produce all documents regarding the Incident, including documents concerning plaintiff's arrest and criminal prosecution (if any), the minutes of any Grand Jury proceedings and criminal court transcripts, and any and all other documents concerning the Incident that are in plaintiff's possession, custody or control.

2. Plaintiff objects to this interrogatory because it is overly broad and duplicative.

a. Subject to and without waiving these objections, Plaintiff directs defendant to Document Request 1.

3. Produce all medical records including, but not limited to, records of doctors, hospitals, psychiatrists, psychologists, social workers, and other counseling services, in plaintiff's possession, custody, or control for treatment received by plaintiff since the Incident and for the five years prior to the Incident, including treatment for any injury resulting from the Incident.

3. Plaintiff objects to this interrogatory because it is overly broad and duplicative.

a. Subject to and without waiving these objections, Plaintiff responds as follows:

See response to Interrogatory 4 and medical records released by HIPPA waivers.

4. Produce all photographs and other audio-visual materials documenting the Incident, the scene of the Incident, and all injuries that resulted from the Incident, including injuries to person and property. Defendants request exact duplicates of the original photographs and audio-visual materials.

4. Plaintiff objects to this interrogatory because it is overly broad and unduly burdensome.

5. Produce all documentation of damages that plaintiff alleges stem from the Incident, including, but not limited to, expenditures for medical, psychiatric, or psychological treatment; lost income; property damage; and attorneys fees. Documentation includes, but is not limited to, paid and unpaid bills, original purchase receipts, cancelled checks, charge slips, appraisals, and warranties.

5. Plaintiff objects to this interrogatory because it is duplicative and

a. Subject to and without waiving these objections, Plaintiff responds as

follows:

See response to Interrogatory 5

6. Produce copies of all subpoenas served on any party, or any individual or entity, concerning this litigation.

6. Plaintiff objects to this interrogatory because it is premature and further investigation is needed to respond to this document request.

7. Produce all documents received in response to any subpoenas served.

7. Plaintiff objects to this interrogatory because it is premature and further investigation is needed to respond to this document request.

8. Produce all documents that relate to all complaints made by plaintiff to any government agency regarding the incident including, but not limited to, the CCRB and IAB of the New York City Police Department.

8. Plaintiff objects to this interrogatory because it is duplicative.

a. Subject to and without waiving these objections, Plaintiff direct defendant to Interrogatory 12.

9. If the plaintiff is claiming lost income in this action, produce plaintiff's federal and state income tax returns since the Incident and for the five years prior to the Incident.

9. Plaintiff objects to this interrogatory because it is duplicative.

a. Subject to and without waiving these objections, Plaintiff directs defendant to release for employment records.

Attached the 2016 -2019 tax returns

10. Produce: (a) all expert disclosures required pursuant to Federal Rule 26(a)(2); (b) any drafts of any reports or other disclosures required by Fed. R. Civ. P. 26(a)(2); (c) all correspondence between plaintiff's counsel, or anyone acting for or on behalf of plaintiff or plaintiff's counsel, and any experts identified in response to Interrogatory No. 18, including, but not limited to, any documents reflecting any fee agreements and any instructions plaintiff's counsel has provided to the expert

regarding the expert's expected testimony and/or examination of plaintiff; and (d) any notes taken by any experts identified in response to Interrogatory No. 18 regarding plaintiff, plaintiff's counsel, the incident alleged in the complaint, this lawsuit, the expert's expected testimony or the expert's retention by plaintiff's counsel in this action.

10. Plaintiff objects to this interrogatory because it is premature and further investigation is needed to respond to this document request.

11. Complete and provide the annexed blank authorizations for release of plaintiff's medical records including, but not limited to, records of doctors, hospitals, psychiatrists, psychologists, social workers and other counseling services for treatment received by plaintiff since the Incident and for the five years prior to the Incident, including treatment for any injury resulting from the Incident.

11. Subject to and without waiving these objections, Plaintiff responds as follows:

Attached the plaintiff's authorizations for release of plaintiff's medical records

12. Complete and provide the annexed blank authorization for access to plaintiff's records that may be sealed pursuant to N.Y. C.P.L. §§ 160.50 and 160.55. Note that the authorization for access to plaintiff's records that may be sealed pursuant to N.Y. C.P.L.160.50 and 160.55 that is annexed hereto differs from the authorization that may have been provided at the outset of this litigation in that it is not limited to documents pertaining to the arrest and/or prosecution that is the subject of this litigation.

12. Subject to and without waiving these objections, Plaintiff responds as follows:

Attached the plaintiff's authorization for access to plaintiff's records that may be sealed pursuant to N.Y. C.P.L. §§ 160.50 and 160.55

13. Complete and provide the annexed blank authorizations for release of employment records for each of plaintiff's employers for the past ten (10) years.

13. Subject to and without waiving these objections, Plaintiff responds as follows:

Attached the plaintiff's authorizations for release of employment records

14. Complete and provide the annexed blank authorization for the unemployment records, if any, of plaintiff.

14. Subject to and without waiving these objections, Plaintiff responds as follows:

Attached the plaintiff's authorization for the unemployment records

15. Complete and provide the annexed blank authorizations for insurance carriers with whom plaintiff has made claims within the past ten (10) years.

15. Plaintiff objects to this interrogatory because it is overly broad and duplicative.

a. Subject to and without waiving these objections, Plaintiff directs defendant to release for Medicaid records

16. Complete and provide the annexed blank authorization for the records of social security disability benefits, if any, received by plaintiff.

16. Subject to and without waiving these objections, Plaintiff responds as follows:

None

17. Complete and provide the annexed blank authorization for plaintiff's Medicare and/or Medicaid records.

17. Subject to and without waiving these objections, Plaintiff responds as follows:

Attached the plaintiff's authorization for plaintiff's Medicaid records

18. Complete and provide the annexed blank authorization for release of the Family Court records.

18. Subject to and without waiving these objections, Plaintiff responds as follows:

Attached the plaintiff's authorization for release of the Family Court records

Xiamin Zeng
Plaintiff *Pro Se*

_____

Dated: 7/8/2020

To: Via U.S. Mail
Stephanie De Angelis Esq.,
New York City Law Department
100 Church Street, Room 3-202
New York, NY 10007

Home Help

History: Select a previously visited page

Clients Case Management Providers Prior Authorization Claims Third Party Financial MARS eCommerce SURS Reference Administration

Client

Client Search > **Client: XIAMIN ZENG - CIN: NN11415T**

Print

Summary Eligibility Previous Information Principal Provider Spenddown Exception/Restriction UT / Dx-Rpt TPL Third Cases Address History PCP History

Client

Trans District:	78-NY HBE	Date Added:	02/14/2012	Change Date:	01/31/2018
SSN:	747-84-9901	Date of Birth:	09/09/1981	Sex:	F-FEMALE
CBIC Card Code:		Age:	37	Relation to HH:	
CBIC Sequence Number:	31	Date of Death:		Language Written:	ENG-ENG
Disability Accommodation Indicator Code:				Language Spoken:	ENG-ENG

Address

Address Line 1:	110 COLUMBIA ST APT 1A	City:	NEW YORK	State:	NY
Address Line 2:		Data Origin Code:	H-HBE	Residential County Code:	60-NEW YORK

Postal Code: 10002 Phone Number: (646)578-1[illegible]

Confidentiality Code:

Available Data

Restriction Exception MC Exemption Principal Provider Third Party Spenddown

Eligibility

14 results. Displaying 1-10 1 | 2 | Next>> | View

Begin Date	End Date	Case Number	Trans Dist	Case Worker	TMA Indicator	Coverage	Aid Category	Fiscal Dist	Office	Status	Override	Change Date	Data Origin Code	Case Type	Ca Co
05/01/2019	12/31/9999	0004786490	78-NY HBE		B-CLNT NO TH	30-MCAID PCP	32-LIF W DEP	66-NY CITY		07-ACTIVE		03/19/2019	H-HBE		
03/01/2018	04/30/2019	0004786490	78-NY HBE		B-CLNT NO TH	30-MCAID PCP	32-LIF W DEP	66-NY CITY		20-CLOSED		03/19/2019	H-HBE		
12/01/2017	02/28/2018	0004786490	78-NY HBE		B-CLNT NO TH	01-ALL BENEFI	32-LIF W DEP	66-NY CITY		07-ACTIVE		01/31/2018	H-HBE		
05/01/2017	11/30/2017	0004786490	78-NY HBE		B-CLNT NO TH	30-MCAID PCP	32-LIF W DEP	66-NY CITY		20-CLOSED		11/15/2017	H-HBE		
03/01/2017	04/30/2017	0004786490	78-NY HBE		B-CLNT NO TH	01-ALL BENEFI	32-LIF W DEP	66-NY CITY		07-ACTIVE		04/11/2017	H-HBE		
06/01/2016	02/28/2017	0004786490	78-NY HBE		B-CLNT NO TH	30-MCAID PCP	32-LIF W DEP	66-NY CITY		20-CLOSED		02/05/2017	H-HBE		
04/01/2016	05/31/2016	0004786490	78-NY HBE		B-CLNT NO TH	01-ALL BENEFI	32-LIF W DEP	66-NY CITY		07-ACTIVE		04/26/2016	H-HBE		
03/02/2016	03/31/2016	0061503048	55-NY CITY	00035	B-CLNT NO TH	30-MCAID PCP	16-TAN-DEP/FP	66-NY CITY	013-013	20-CLOSED		03/01/2016	D-WMS NYC	11-FAMASTFA	
03/02/2016	03/02/2016	0061503048	55-NY CITY	00035	B-CLNT NO TH	30-MCAID PCP	16-TAN-DEP/FP	66-NY CITY	013-013	07-ACTIVE		03/01/2016	D-WMS NYC	11-FAMASTFA	
12/01/2015	03/01/2016	0061503048	55-NY CITY	00035	B-CLNT NO TH	30-MCAID PCP	16-TAN-DEP/FP	66-NY CITY	013-013	20-CLOSED		03/01/2016	D-WMS NYC	11-FAMASTFA	

MC (Managed Care)

Provider ID	Provider Name	Plan Code	Package	Begin Date	End Date	Trans District	Case Worker	Change Date	Data Origin Code	PCP Subscriber	PCP Member	PCP Group Code	PCP Policy	HIOS ID
01479620	HEALTH FIRST PHSP INC	SF-HFPHSP	66-BP66	03/01/2019	04/30/2019	66-NY CITY	834HP	02/12/2019	H-HBE	0004786490	NN11415T			91237MC10C
01751046	FIDELIS CARE	SP-FIDEL MMC	66-BP66	01/01/2012	09/30/2012	66-NY CITY	NYEMV	02/28/2012	D-WMS NYC					
01751046	FIDELIS CARE	SP-FIDEL MMC	66-BP66	12/01/2013	03/31/2016	66-NY CITY	NYEMV	11/14/2013	D-WMS NYC					
01751046	FIDELIS CARE	SP-FIDEL MMC	66-BP66	06/01/2016	02/28/2017	66-NY CITY	511H	11/05/2016	H-HBE	742115930	74211593000			25303MC10C
01751046	FIDELIS CARE	SP-FIDEL MMC	66-BP66	05/01/2017	11/30/2017	66-NY CITY	834HP	04/11/2017	H-HBE	742115930	74211593000			25303MC10C
01751046	FIDELIS CARE	SP-FIDEL MMC	66-BP66	03/01/2018	02/28/2019	66-NY CITY	511H	02/12/2019	H-HBE	742115930	74211593000			25303MC10C
01751046	FIDELIS CARE	SP-FIDEL MMC	66-BP66	03/01/2019	12/31/9999	66-NY CITY	511H	06/18/2019	H-HBE	742115930	74211593000			25303MC10C

MC (Managed Care) Coverages

80 results. Displaying 1-10 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | Next>> | View

Effective Date	Plan Code	Package	Coverages
02/01/2015	SF-HFPHSP	66-BP66	A-INPT HOSP

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
XIAMIN ZENG	[redacted]	[redacted]
Patient Address: [redacted]		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form.

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information: [redacted]

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis Esq 100 Church Street. New York NY 10007

9. (a). Specific information to be released:

☒ Medical Record from (insert date) 1/1/2018 to (insert date) present

☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

Include: *(Indicate by Initialing)*

XZ **Alcohol/Drug Treatment**

XZ **Mental Health Information**

XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a government agency, listed here:

_____

(Attorney' Firm Name or Government Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☒ Other: Litigation	upon the exhaustion of appeals
12. If not the patient, name of person signing form:	13. **Authority** to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 7/8/20

Signature of patient or representative authorized by law.

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
XIAMIN ZENG	[redacted]	[redacted]
Patient Address		
[redacted]		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
[redacted]

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis Esq 100 Church Street. New York NY 10007

9. (a). Specific information to be released:

☒ Medical Record from (insert date) 1/1/2015 to (insert date) present

☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

Include: *(Indicate by Initialing)*

XZ **Alcohol/Drug Treatment**

XZ **Mental Health Information**

XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here_____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a government agency, listed here:

_____

(Attorney/ Firm Name or Government Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☒ Other: Litigation	upon the exhaustion of appeals
12. If not the patient, name of person signing form:	13. **Authority** to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

JZ

_____ Date: 7/8/20

Signature of patient or representative authorized by law.

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
XIAMIN ZENG	[redacted]	[redacted]
Patient Address		
[redacted]		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form.

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
[redacted]

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis Esq. 100 Church Street, New York, NY 10007

9. (a). Specific information to be released:

☒ Medical Record from (insert date) 1/1/2018 to (insert date) present

☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: *(Indicate by Initialing)*

XZ **Alcohol/Drug Treatment**

XZ **Mental Health Information**

XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here_____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a government agency, listed here:

_____

(Attorney/ Firm Name or Government Agency Name)

10. Reason for release of information:
☐ At request of individual
☒ Other: Litigation

11. Date or event on which this authorization will expire:
upon the exhaustion of appeals

12. If not the patient, name of person signing form:

13. **Authority** to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 7/8/20

Signature of patient or representative authorized by law.

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
XIAMIN ZENG	[redacted]	[redacted]
Patient Address: [redacted]		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form.

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information: [redacted]

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis Esq 100 Church Street. New York NY 10007

9. (a). Specific information to be released:

☒ Medical Record from (insert date) 1/1/2018 to (insert date) Present

☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: *(Indicate by Initialing)*

XZ **Alcohol/Drug Treatment**

XZ **Mental Health Information**

XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here_____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a government agency, listed here:

_____

(Attorney/ Firm Name or Government Agency Name)

10. Reason for release of information:
☐ At request of individual
☒ Other: Litigation

11. Date or event on which this authorization will expire:
upon the exhaustion of appeals

12. If not the patient, name of person signing form:

13. **Authority** to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 7/8/20

Signature of patient or representative authorized by law.

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
XIAMIN ZENG	[redacted]	[redacted]
Patient Address		
[redacted]		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form.

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
[redacted]

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis Esq 100 Church Street. New York NY 10007

9. (a). Specific information to be released:

☒ Medical Record from (insert date) 1/1/2018 to (insert date) present

☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: *(Indicate by Initialing)*

XZ **Alcohol/Drug Treatment**

XZ **Mental Health Information**

XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here_____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a government agency, listed here:

_____

(Attorney's Firm Name or Government Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☒ Other: Litigation	upon the exhaustion of appeals
12. If not the patient, name of person signing form:	13. **Authority** to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 7/8/20

Signature of patient or representative authorized by law.

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
XIAMIN ZENG	[redacted]	[redacted]
Patient Address		
[redacted]		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
[redacted]

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis Esq 100 Church Street New York NY 10007

9. (a). Specific information to be released:

☒ Medical Record from (insert date) 1/1/2018 to (insert date) present

☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: *(Indicate by Initialing)*

XZ **Alcohol/Drug Treatment**

XZ **Mental Health Information**

XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here_____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a government agency, listed here:

_____

(Attorney/ Firm Name or Government Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☒ Other: Litigation	upon the exhaustion of appeals
12. If not the patient, name of person signing form:	13. **Authority** to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 7/8/20

Signature of patient or representative authorized by law.

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
XIAMIN ZENG	[redacted]	[redacted]

Patient Address: [redacted]

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information: [redacted]

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis Esq 100 Church Street New York NY 10007

9. (a). Specific information to be released:

☒ Medical Record from (insert date) 1/1/2018 to (insert date) present

☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

Include: *(Indicate by Initialing)*

XZ **Alcohol/Drug Treatment**

XZ **Mental Health Information**

XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a government agency, listed here:

_____

(Attorney/ Firm Name or Government Agency Name)

10. Reason for release of information:
☐ At request of individual
☒ Other: Litigation

11. Date or event on which this authorization will expire:
upon the exhaustion of appeals

12. If not the patient, name of person signing form:

13. **Authority** to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 7/8/20

Signature of patient or representative authorized by law.

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
XIAMIN ZENG	[redacted]	[redacted]

Patient Address

[redacted]

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form.

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

[redacted]

8. Name and address of person(s) or category of person to whom this information will be sent:

Stephanie De Angelis Esq 100 Church Street, New York, NY 10007

9. (a). Specific information to be released:

☒ Medical Record from (insert date) 1/1/2018 to (insert date) present

☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: *(Indicate by Initialing)*

XZ **Alcohol/Drug Treatment**

XZ **Mental Health Information**

XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here_____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a government agency, listed here:

_____

(Attorney/ Firm Name or Government Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☒ Other: Litigation	upon the exhaustion of appeals
12. If not the patient, name of person signing form:	13. **Authority** to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 7/8/20

Signature of patient or representative authorized by law.

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
XIAMIN ZENG	[redacted]	[redacted]
Patient Address: [redacted]		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information: [redacted]

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis Esq. 100 Church Street, New York NY 10007

9. (a). Specific information to be released:

☒ Medical Record from (insert date) 1/1/2018 to (insert date) Present

☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: *(Indicate by Initialing)*

XZ **Alcohol/Drug Treatment**

XZ **Mental Health Information**

XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here_____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a government agency, listed here:

_____

(Attorney/ Firm Name or Government Agency Name)

10. Reason for release of information:
☐ At request of individual
☒ Other: Litigation

11. Date or event on which this authorization will expire:
upon the exhaustion of appeals

12. If not the patient, name of person signing form:

13. **Authority** to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 7/8/20

Signature of patient or representative authorized by law.

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

OCA Official Form No. 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
XIAMIN ZENG	[redacted]	[redacted]

Patient Address
[redacted]

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form.

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
[redacted]

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis Esq 100 Church Street, New York NY 10007

9. (a). Specific information to be released:

☒ Medical Record from (insert date) 1/1/2018 to (insert date) Present

☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: *(Indicate by Initialing)*

XZ **Alcohol/Drug Treatment**

XZ **Mental Health Information**

XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here_____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a government agency, listed here:

_____

(Attorney/ Firm Name or Government Agency Name)

10. Reason for release of information:
☐ At request of individual
☒ Other: Litigation

11. Date or event on which this authorization will expire:
upon the exhaustion of appeals

12. If not the patient, name of person signing form:

13. **Authority** to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 7/8/20

Signature of patient or representative authorized by law.

Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

XIAMIN ZENG,

19-CV-3218 (JGK) (KHP)

Plaintiff,

-against-

RELEASE FOR PSYCHOTHERAPY NOTES

JOHN CHELL; GARY DENEZZO; GEORGE TAVAREZ; CITY OF NEW YORK; DIEGO ANDRIANZAN; DANIELLE FEBUS,

Defendants.

TO: [redacted] [Health Care Provider]
[redacted] [Address]
[redacted] [City, State, Zip]

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations, 45 CFR § 164.508, YOU ARE HEREBY AUTHORIZED AND DIRECTED to furnish to JAMES E. JOHNSON, Corporation Counsel of the City of New York, attorney for the defendants in the above-captioned case, or to his authorized representative, a certified copy of all psychotherapy notes of XIAMIN ZENG (Date of Birth: [redacted]; SS #: [redacted]) who was examined or treated in your hospital or by you on or about [redacted]

The reason for this release of information is (a) at the request of individual, or (b) _____. This authorization will terminate upon the resolution of my lawsuit. The aforementioned expiration date has not passed as this matter is ongoing.

I have the right to revoke this authorization in writing by providing a signed, written notice of revocation to the health care provider listed above and to James E. Johnson, except to the extent that the provider listed above has taken action in reliance on this authorization. Medical providers may not condition treatment or payment on whether the above-listed patient executes this authorization. The information disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA).

Dated: New York, New York
7/8, 2020

XIAMIN ZENG

STATE OF NEW YORK)
: SS:
COUNTY OF Queens)

On the 8th day of July, 2020, before me personally came and appeared XIAMIN ZENG, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that she executed the same.

FUXIANG YE
Notary Public - State of New York
NO. 01YE6364436
Qualified in Queens County
My Commission Expires Sep 18, 2021

NOTARY PUBLIC

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
----------x

XIAMIN ZENG,

19-CV-3218 (JGK) (KHP)

Plaintiff,

-against-

RELEASE FOR PSYCHOTHERAPY NOTES

JOHN CHELL; GARY DENEZZO; GEORGE TAVAREZ; CITY OF NEW YORK; DIEGO ANDRIANZAN; DANIELLE FEBUS,

Defendants.
----------x

TO: [redacted] [Health Care Provider]
[redacted] [Address]
[redacted] [City, State, Zip]

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations, 45 CFR § 164.508, YOU ARE HEREBY AUTHORIZED AND DIRECTED to furnish to JAMES E. JOHNSON, Corporation Counsel of the City of New York, attorney for the defendants in the above-captioned case, or to his authorized representative, a certified copy of all psychotherapy notes of XIAMIN ZENG (Date of Birth: [redacted]; SS #: [redacted]) who was examined or treated in your hospital or by you on or about [redacted].

The reason for this release of information is (a) at the request of individual, or (b) _____. This authorization will terminate upon the resolution of my lawsuit. The aforementioned expiration date has not passed as this matter is ongoing.

I have the right to revoke this authorization in writing by providing a signed, written notice of revocation to the health care provider listed above and to James E. Johnson, except to the extent that the provider listed above has taken action in reliance on this authorization. Medical providers may not condition treatment or payment on whether the above-listed patient executes this authorization. The information disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA).

Dated: New York, New York
7/8, 2020

XIAMIN ZENG

STATE OF NEW YORK)
: SS:
COUNTY OF Queens)

On the 8th day of July, 2020, before me personally came and appeared XIAMIN ZENG, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that she executed the same.

FUXIANG YE
Notary Public – State of New York
NO. 01YE6364486
Qualified in Queens County
My Commission Expires Sep 18, 2021

NOTARY PUBLIC

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

XIAMIN ZENG,

Plaintiff,

-against-

JOHN CHELL; GARY DENEZZO; GEORGE TAVAREZ; CITY OF NEW YORK; DIEGO ANDRIANZAN; DANIELLE FEBUS,

Defendants.

MEDICARE RECORDS RELEASE

19-CV-3218 (JGK) (KHP)

TO: FOIA Service Center/FOIA Public Liaison
Centers for Medicare Services
26 Federal Plaza
New York, NY 10278

YOU ARE HEREBY AUTHORIZED and I hereby request you to furnish to JAMES E. JOHNSON, Corporation Counsel of the City of New York, attorney for the defendants in the above-captioned case, or to his authorized representative, a **CERTIFIED COPY** of the entire file of XIAMIN ZENG (Date of Birth [redacted]; SS #[redacted]), who received Medicare benefits from February 2018 to present.

The Medicare file authorized for release includes, but is not limited to, any and all applications, determinations, correspondence, payments or credits made to such person.

The reason for this release of information is (a) at the request of individual, or (b) _____.

This Authorization will expire at the conclusion of the above-captioned litigation.

I understand that I have the right to revoke this authorization at any time. I must do so by writing to the same person(s) or class of persons that I directed this authorization to. The revocation will not apply to information that has already been released in response to this authorization.

I understand that my refusal to authorize disclosure of my personal medical information will have no effect on my enrollment, eligibility for benefits, or the amount Medicare pays for the health services I receive.

I understand that information disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by law.

Dated: New York, New York
7/8, 2020

XIAMIN ZENG

STATE OF NEW YORK)
: SS:
COUNTY OF Queens)

On the 8th day of July, 2020, before me personally came and appeared XIAMIN ZENG, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that she executed the same.

NOTARY PUBLIC

FUXIANG YE
Notary Public - State of New York
NO. 01YE6364486
Qualified in Queens County
My Commission Expires Sep 18, 2021

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH INSURANCE PROGRAMS
AUTHORIZATION TO RELEASE PROTECTED MEDICAID MEMBER INFORMATION TO A THIRD PARTY

Medicaid Member Name (required): XIAMIN ZENG

Date of Birth (required): [redacted] / [redacted] / [redacted]

At least one of the following identification numbers is required, preferably both.

Client Identification Number (CIN): [redacted] Social Security Number (SSN): [redacted]

Persons/organizations authorized to receive or use the information:

Name: Stephanie De Angelis

Address: 100 Church St

City: New York State: NY Zip: 10007

Phone Number: (212) 356-3513

Dates authorized: ☐ All OR From 03 / 01 / 2018 To ___/___/___ OR ☒ To Present

Purpose of the use/disclosure: Legal Matter

Will the person/program requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes X No ___

1. I understand that my health care and the payments for my health care will not be affected if I do not sign this form except in some situations when information is needed for the health plan's eligibility or enrollment determinations relating to the individual.

2. I understand, with few exceptions, that I may see and copy the information described on this form if I ask for it, and that I may get a copy of this form after I sign it.

3. I may revoke this authorization at any time by notifying the Department of Health in writing at the address below, but, if I do, it will not have any effect on actions that the Department took before they received the revocation. If not previously revoked, this authorization will expire upon completion of this request or one year from the date this form is signed, whichever comes first.

4. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan, health care provider or clearinghouse, the released information may no longer be protected by federal privacy regulations, and therefore the recipient of the confidential data may re-disclose the confidential data.

By signing this form I understand that I am allowing the New York State Department of Health to use or disclose all of the payment information for the Medical Member as indicated above, including data on certain conditions such as HIV/AIDS, Mental Health and Alcohol and Substance Abuse. I specially authorize release of such information to the person(s) indicated above as the recipient.

[signature] 7/8/20

Signature of Medicaid member of Agent — Date

If not member, name of person signing for member — Authority to sign on behalf of member

Witness Signature — Witness Name

Please return to:
Medical Data Warehouse - CDRs
NYSDOH - MISCNY
ESP P1-11S Dock J
Albany, New York 12237

ACHARY W. CARTER
Corporation Counsel

The City of New York
LAW DEPARTMENT
100 CHURCH STREET
NEW YORK, N.Y. 10007

RITA SHAPSIS
Phone: (212) 356-3543
Fax: (212) 356-3509
rshapsis@law.nyc.gov

June 11, 2019

Edgar Mikel Rivera, Esq.
The Harman Firm, LLP
381 Park Avenue South
Ste 1220
New York, NY 10016

Re: Xiamin Zeng v. John Chell, et al.
19CV03218

Dear Mr. Rivera:

This office is in receipt of the complaint in the above-referenced action. The complaint alleges physical and/or emotional injuries as a result of the incident described in the complaint. In order for this lawsuit to proceed, the medical records pertaining to the incident described in the complaint must be available to defendants. Enclosed please find a medical release form.

Please have your client execute the release before a notary public and return the release to me within one week of the above date. **On the release, your client should provide the name and address of the medical provider, the date or dates of treatment, names or aliases used, the client's social security number and the client's date of birth. Also please have your client check off all of the boxes on the release.** The social security number and the date of birth are needed so that the medical provider can identify the proper records which concern plaintiff's treatment. Until the executed release is received by this office, we cannot secure the relevant medical records. Consequently, we will not be able to properly assess this case, or proceed to discovery. Your failure to promptly return this release will unduly delay this litigation. If you have any questions, please do not hesitate to call me.

Thank you for your attention to this matter.

Very truly yours,

Rita Shapsis
Paralegal
Special Federal Litigation Division

Enc.
cc: Stephanie De Angelis, Esq.
Assistant Corporation Counsel

'D STATES DISTRICT COURT
'ERN DISTRICT OF NEW YORK

----------x

..AMIN ZENG,

Plaintiff,

-against-

JOHN CHELL, ET AL.,

Defendants

----------x

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

19CV03218 (JGK)

TO: [redacted]
NAME AND ADDRESS OF MEDICAL PROVIDER

I authorize the use and disclosure of XIAMIN ZENG'S health information as described below.

YOU ARE HEREBY AUTHORIZED to furnish to ZACHARY W. CARTER, Corporation Counsel of the City of New York, attorney for the defendants in the above-captioned case, or to his authorized representative, a **CERTIFIED COPY** of the entire medical or hospital record of XIAMIN ZENG (Date of Birth: [redacted]; SS # [redacted]) who was examined or treated in your hospital or by you on or about April 2018.

The medical record authorized for release includes any and all x-rays of said person and any and all diagnostic tests, studies, or reports of examinations relating to such person.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol, and drug abuse.

This information may be disclosed to and used by the following organization:
The Office of the Corporation Counsel
100 Church Street
New York, NY 10007
for the purpose of defense of civil litigation

I understand I have the right to revoke this authorization at any time. In understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. Unless otherwise revoked, this authorization will expire on the following date, event or condition: Upon settlement. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

Defendants

I understand that authorization the disclosure of this health information is voluntary, I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact (Name of Medical Provider's Risk Management Office).

Dated: New York, New York
June 19, 2019

XIAMIN ZENG

STATE OF NEW YORK)
: ss:
COUNTY OF New York)

On the 19 day of June, 2019, before me personally came and appeared XIAMIN ZENG, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that she executed the same.

NOTARY PUBLIC

EDGAR M RIVERA
Notary Public - State of New York
NO. 02RI6331148
Qualified in New York County
My Commission Expires Oct 5, 2019

NYCHHC HIPAA Authorization to Disclose Health Information

ALL FIELDS MUST BE COMPLETED

THIS FORM MAY NOT BE USED FOR RESEARCH OR MARKETING, FUNDRAISING OR PUBLIC RELATIONS AUTHORIZATIONS

PATIENT NAME/ADDRESS	DATE OF BIRTH	PATIENT SSN
Xiamin Zeng [redacted]	[redacted]	[redacted]
	MEDICAL RECORD NUMBER	TELEPHONE NUMBER
		[redacted]

NAME OF HEALTH PROVIDER TO RELEASE INFORMATION: [redacted]

SPECIFIC INFORMATION TO BE RELEASED:
Information Requested: _____
Treatment Dates from: April 2018 to present

NAME & ADDRESS OF PERSON OR ENTITY TO WHOM INFO. WILL BE SENT: Stephanie De Angelis, Esq. The Office of Cooperation Counsel 100 Church St. New York, NY 10007

INFORMATION TO BE RELEASED (If the box is checked, you are authorizing the release of that type of information). Please note: unless all of the boxes are checked, we may be unable to process your request.

- ☒ Alcohol and/or Substance Abuse Program Information
- ☒ Mental Health Information
- ☒ Genetic Testing Information
- ☒ HIV/AIDS-related Information

REASON FOR RELEASE OF INFORMATION
- ☒ Legal Matter
- ☐ Individual's Request
- ☐ Other (please specify): _____

WHEN WILL THIS AUTHORIZATION EXPIRE? (Please check one)
- ☒ Event: upon exhaustion of appeals
- ☐ On this date: _____

I, or my authorized representative, authorize the use or disclosure of my medical and/or billing information as I have described on this form.

I understand that my medical and/or billing information could be re-disclosed and no longer protected by federal health information privacy regulations if the recipient(s) described on this form are not required by law to protect the privacy of the information.

I understand that if my medical and/or billing records contain information relating to **ALCOHOL** or **SUBSTANCE ABUSE, GENETIC TESTING, MENTAL HEALTH,** and/or **CONFIDENTIAL HIV/AIDS RELATED INFORMATION,** this information will not be released to the person(s) I have indicated unless I check the box(es) for this information on this form.

I understand that if I am authorizing the use or disclosure of HIV/AIDS-related information, the recipient(s) is prohibited from using or re-disclosing any HIV/AIDS-related information without my authorization, unless permitted to do so under federal or state law. I also understand that I have a right to request a list of people who may receive or use my HIV/AIDS-related information without authorization. If I experience discrimination because of the use or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 212.480.2493 or the New York City Commission of Human Rights at 212.306.7450. These agencies are responsible for protecting my rights.

I understand that I have a right to refuse to sign this authorization and that my health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form. I also understand that if I refuse to sign this authorization, NYCHHC cannot honor my request to disclose my medical and/or billing information.

I understand that I have a right to request to inspect and/or receive a copy of the information described on this authorization form by completing a Request for Access Form. I also understand that I have a right to receive a copy of this form after I have signed it.

I understand that if I have signed this authorization form to use or disclose my medical and/or billing information, I have the right to revoke it at any time, except to the extent that NYCHHC has already taken action based on my authorization or that the authorization was obtained as a condition for obtaining insurance coverage.

To revoke this authorization, please contact the facility Health Information Management department processing this request.

I have read this form and all of my questions have been answered. By signing below, I acknowledge that I have read and accept all of the above.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE	IF NOT PATIENT, PRINT NAME & CONTACT INFORMATION OF PERSONAL REPRESENTATIVE SIGNING FORM
DATE: 06/19/2019	DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY TO ACT ON BEHALF OF PATIENT

If HHC has requested this authorization, the patient or his/her Personal Representative must be provided a copy of this form after it has been signed.

HHC USE ONLY	
Date Received:	Initials of HIM employee processing request:
Date Completed:	Comments:

NYCHHC HIPAA Authorization 2413. Revised 09-05

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
XIAMIN ZENG	[redacted]	[redacted]
Patient Address [redacted]		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information: [redacted]

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis, Esq., 100 Church Street, New York, NY 10007

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

- XZ **Alcohol/Drug Treatment**
- XZ **Mental Health Information**
- XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: **litigation**	**upon the exhaustion of appeals**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 6/19/19

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name XIAMIN ZENG	Date of Birth [redacted]	Social Security Number [redacted]
Patient Address [redacted]		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
[redacted]

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis, Esq. 100 Church Street, New York, NY 10007

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

- XZ **Alcohol/Drug Treatment**
- XZ **Mental Health Information**
- XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: **litigation**	**upon the exhaustion of appeals**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

[signature] Date: 6/19/19

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name XIAMIN ZENG	Date of Birth [redacted]	Social Security Number [redacted]
Patient Address [redacted]		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
[redacted]

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis, Esq. 100 Church Street, New York, NY 10007

9(a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

Include: (*Indicate by Initialing*)

XZ **Alcohol/Drug Treatment**

XZ **Mental Health Information**

XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☑ Other: **litigation**	11. Date or event on which this authorization will expire: **upon the exhaustion of appeals**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 6/19/19

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name XIAMIN ZENG	Date of Birth [redacted]	Social Security Number [redacted]
Patient Address [redacted]		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
[redacted]

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie DeAngelis, Esq., 100 Church Street, New York, NY 10007

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: *(Indicate by Initialing)*

- XZ **Alcohol/Drug Treatment**
- XZ **Mental Health Information**
- XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: **litigation**	**upon the exhaustion of appeals**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 6/19/19

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name XIAMIN ZENG	Date of Birth [redacted]	Social Security Number [redacted]
Patient Address [redacted]		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
[redacted]

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie DeAngelis, Esq. 100 Church Street, New York, NY 10007

9(a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

Include: (*Indicate by Initialing*)

XZ **Alcohol/Drug Treatment**

XZ **Mental Health Information**

XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: **litigation**	**upon the exhaustion of appeals**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 6/19/19

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name XIAMIN ZENG	Date of Birth [redacted]	Social Security Number [redacted]
Patient Address [redacted]		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
[redacted]

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis, Esq. 100 Church Street, New York, NY 10007

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

- XZ **Alcohol/Drug Treatment**
- XZ **Mental Health Information**
- XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: **litigation**	**upon the exhaustion of appeals**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 6/19/19

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name XIAMIN ZENG	Date of Birth [redacted]	Social Security Number [redacted]
Patient Address [redacted]		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
[redacted]

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis, Esq. 100 Church Street, New York, NY 10007

9(a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

Include: (*Indicate by Initialing*)

XZ **Alcohol/Drug Treatment**

XZ **Mental Health Information**

XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: **litigation**	**upon the exhaustion of appeals**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 6/19/19

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name XIAMIN ZENG	Date of Birth [redacted]	Social Security Number [redacted]
Patient Address [redacted]		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information: [redacted]

8. Name and address of person(s) or category of person to whom this information will be sent: Stephanie DeAngelis, Esq., 100 Church Street, New York, NY 10007

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

- XZ **Alcohol/Drug Treatment**
- XZ **Mental Health Information**
- XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: **litigation**	**upon the exhaustion of appeals**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Date: 6/19/19

_____
Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
XIAMIN ZENG	[redacted]	[redacted]
Patient Address [redacted]		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information: [redacted]

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie DeAngelis, Esq., 100 Church Street, New York, NY 10007

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

- XZ **Alcohol/Drug Treatment**
- XZ **Mental Health Information**
- XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: **litigation**	**upon the exhaustion of appeals**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 6/19/19

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name XIAMIN ZENG	Date of Birth [redacted]	Social Security Number [redacted]
Patient Address [redacted]		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information: [redacted]

8. Name and address of person(s) or category of person to whom this information will be sent: Stephanie De Angelis, Esq. 100 Church Street, New York, NY, 10007

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

- XZ **Alcohol/Drug Treatment**
- XZ **Mental Health Information**
- XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: **litigation**	**upon the exhaustion of appeals**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 6/19/19

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name XIAMIN ZENG	Date of Birth [redacted]	Social Security Number [redacted]
Patient Address [redacted]		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT,** except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
[redacted]

8. Name and address of person(s) or category of person to whom this information will be sent:
Stephanie De Angelis, Esq., 100 Church Street, New York, NY 10007

9(a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: (*Indicate by Initialing*)

XZ **Alcohol/Drug Treatment**

XZ **Mental Health Information**

XZ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider)

to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: **litigation**	**upon the exhaustion of appeals**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 6/19/19

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Form **1040** Department of the Treasury—Internal Revenue Service (99)
U.S. Individual Income Tax Return **2018** OMB No. 1545-0074 IRS Use Only—Do not write or staple in this space.

Filing status: ☐ Single ☐ Married filing jointly ☐ Married filing separately ☒ Head of household ☐ Qualifying widow(er)

Your first name and initial	Last name	Your social security number
XIAMIN	ZENG	[redacted]

Your standard deduction: ☐ Someone can claim you as a dependent ☐ You were born before January 2, 1954 ☐ You are blind

If joint return, spouse's first name and initial	Last name	Spouse's social security number

Spouse standard deduction: ☐ Someone can claim your spouse as a dependent ☐ Spouse was born before January 2, 1954 ☐ Spouse is blind ☐ Spouse itemizes on a separate return or you were a dual-status alien

☒ Full-year health care coverage or exempt (see instr.)

Home address (number and street). If you have a P.O. box, see instructions.	Apt. no.	Presidential Election Campaign (see instr.) ☐ You ☐ Spouse
[redacted]		

City, town or post office, state, and ZIP code. If you have a foreign address, attach Schedule 6. → [redacted]

If more than four dependents, see instr. and ✓ here ▶ ☐

Dependents (see instructions): (1) First name / Last name	(2) Social security number	(3) Relationship to you	(4) ✓ if qualifies for (see instr.) Child tax credit	Credit for other dependents
[redacted]	[redacted]	[redacted]	☒	☐
			☐	☐
			☐	☐
			☐	☐

Sign Here Under penalties of perjury, I declare that I have examined this return and accompanying schedules and statements, and to the best of my knowledge and belief, they are true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Joint return? See instructions. Keep a copy for your records.

Your signature	Date	Your occupation	If the IRS sent you an Identity Protection PIN, enter it here (see inst.)
Spouse's signature. If a joint return, **both** must sign.	Date	Spouse's occupation	If the IRS sent you an Identity Protection PIN, enter it here (see inst.)

Paid Preparer Use Only

Preparer's name	Preparer's signature	PTIN	Check if:
EVA CEN EA	EVA CEN EA	[redacted]	☐ 3rd Party Designee
Firm's name ▶ [redacted]		Firm's EIN [redacted]	☐ Self-employed
Firm's address ▶ [redacted]		Phone no. [redacted]	

For Disclosure, Privacy Act, and Paperwork Reduction Act Notice, see separate instructions. Form **1040** (2018)

DAA

Form 1040 (2018) XIAMIN ZENG [redacted] Page 2

	1	Wages, salaries, tips, etc. Attach Form(s) W-2				1	
	2a	Tax-exempt interest	2a		b Taxable interest	2b	
	3a	Qualified dividends	3a		b Ordinary dividends	3b	
	4a	IRAs, pensions, and annuities	4a		b Taxable amount	4b	
Attach Form(s) W-2. Also attach Form(s) W-2G and 1099-R if tax was withheld.	5a	Social security benefits	5a		b Taxable amount	5b	
	6	Total income. Add lines 1 through 5. Add any amount from Schedule 1, line 22				6	0
	7	Adjusted gross income. If you have no adjustments to income, enter the amount from line 6; otherwise subtract Schedule 1, line 36, from line 6				7	0
Standard Deduction for –	8	**Standard deduction or itemized deductions** (from Schedule A)				8	18,000
• Single or married filing separately, $12,000	9	Qualified business income deduction (see instructions)				9	
• Married filing jointly or Qualifying widow(er), $24,000	10	Taxable income. Subtract lines 8 and 9 from line 7. If zero or less, enter -0-				10	0
• Head of household, $18,000	11	a Tax (see instr.) 0 (check if any from: 1 ☐ Form(s) 8814 2 ☐ Form 4972 3 ☐)					
• If you checked any box under Standard deduction, see instructions.		b **Add** any amount from Schedule 2 and check here ▶ ☐				11	0
	12	a Child tax credit/credit for other dependents			b **Add** any amount from Schedule 3 and check here ▶ ☐	12	
	13	Subtract line 12 from line 11. If zero or less, enter -0-				13	0
	14	Other taxes. Attach Schedule 4				14	
	15	Total tax. Add lines 13 and 14				15	0
	16	Federal income tax withheld from Forms W-2 and 1099				16	
	17	Refundable credits: a EIC (see instr.) b Sch 8812 c Form 8863					
		Add any amount from Schedule 5				17	
	18	Add lines 16 and 17. These are your total payments				18	
	19	If line 18 is more than line 15, subtract line 15 from line 18. This is the amount you **overpaid**				19	
Refund	20a	Amount of line 19 you want **refunded to you.** If Form 8888 is attached, check here ▶ ☐				20a	
Direct deposit? See instructions.	▶ b	Routing number		▶ c Type: ☐ Checking ☐ Savings			
	▶ d	Account number					
	21	Amount of line 19 you want **applied to your 2019 estimated tax** ▶	21				
Amount You Owe	22	**Amount you owe.** Subtract line 18 from line 15. For details on how to pay, see instructions ▶				22	0
	23	Estimated tax penalty (see instructions) ▶	23				

Go to *www.irs.gov/Form1040* for instructions and the latest information. Form **1040** (2018)

DAA

Form **1040** Department of the Treasury—Internal Revenue Service (99) **U.S. Individual Income Tax Return** **2019** OMB No. 1545-0074 IRS Use Only—Do not write or staple in this space.

Filing Status Check only one box. [X] Single [ ] Married filing jointly [ ] Married filing separately (MFS) [ ] Head of household (HOH) [ ] Qualifying widow(er) (QW)
If you checked the MFS box, enter the name of spouse. If you checked the HOH or QW box, enter the child's name if the qualifying person is a child but not your dependent ▶

Your first name and middle initial	Last name	Your social security number
XTAMIN	ZENG	[redacted]
If joint return, spouse's first name and middle initial	Last name	Spouse's social security number
Home address (number and street). If you have a P.O. box, see instructions. [redacted]	Apt. no.	Presidential Election Campaign: Check here if you, or your spouse if filing jointly, want $3 to go to this fund. Checking a box below will not change your tax or refund. [ ] You [ ] Spouse
City, town or post office, state, and ZIP code. If you have a foreign address, also complete spaces below (see instructions). [redacted]		
Foreign country name	Foreign province/state/county	Foreign postal code

If more than four dependents, see instr. and ✓ here ▶ [ ]

Standard Deduction Someone can claim: [ ] You as a dependent [ ] Your spouse as a dependent
[ ] Spouse itemizes on a separate return or you were a dual-status alien

Age/Blindness You: [ ] Were born before January 2, 1955 [ ] Are blind Spouse: [ ] Was born before January 2, 1955 [ ] Is blind

Dependents (see instructions):

(1) First name / Last name	(2) Social security number	(3) Relationship to you	(4) ✓ if qualifies for (see instructions): Child tax credit	Credit for other dependents

1	Wages, salaries, tips, etc. Attach Form(s) W-2			1	
2a	Tax-exempt interest	2a	b Taxable interest. Attach Sch. B if required	2b	
3a	Qualified dividends	3a	b Ordinary divs. Att. Sch. B if req	3b	
4a	IRA distributions	4a	b Taxable amount	4b	
c	Pensions and annuities	4c	d Taxable amount	4d	
5a	Soc. sec. ben.	5a	b Taxable amount	5b	
6	Capital gain or (loss). Attach Schedule D if required. If not required, check here ▶ [ ]			6	
7a	Other income from Schedule 1, line 9			7a	0
b	Add lines 1, 2b, 3b, 4b, 4d, 5b, 6, and 7a. This is your **total income** ▶			7b	0
8a	Adjustments to income from Schedule 1, line 22			8a	0
b	Subtract line 8a from line 7b. This is your **adjusted gross income** ▶			8b	0
9	**Standard deduction or itemized deductions** (from Schedule A)	9	12,200		
10	Qualified business income deduction. Attach Form 8995 or Form 8995-A	10			
11a	Add lines 9 and 10			11a	12,200
b	**Taxable income.** Subtract line 11a from line 8b. If zero or less, enter -0-			11b	0

Standard Deduction for—
- Single or Married filing separately, $12,200
- Married filing jointly or Qualifying widow(er), $24,400
- Head of household, $18,350
- If you checked any box under *Standard Deduction*, see instructions.

For Disclosure, Privacy Act, and Paperwork Reduction Act Notice, see separate instructions. Form **1040** (2019)

DAA

Form 1040 (2019) XIAMIN ZENG [redacted] Page 2

	12a	**Tax** (see instr.) Check if any from Form(s): 1 ☐ 8814 2 ☐ 4972 3 ☐	12a	0
	b	Add Schedule 2, line 3, and line 12a and enter the total ▶	12b	0
	13a	Child tax credit or credit for other dependents	13a	-
	b	Add Schedule 3, line 7, and line 13a and enter the total ▶	13b	
	14	Subtract line 13b from line 12b. If zero or less, enter -0-	14	0
	15	Other taxes, including self-employment tax, from Schedule 2, line 10	15	
	16	Add lines 14 and 15. This is your **total tax** ▶	16	0
	17	Federal income tax withheld from Forms W-2 and 1099	17	
• If you have a qualifying child, attach Sch. EIC. • If you have nontaxable combat pay, see instructions.	18	Other payments and refundable credits:		
	a	Earned income credit (EIC)	18a	
	b	Additional child tax credit. Attach Schedule 8812	18b	
	c	American opportunity credit from Form 8863, line 8	18c	
	d	Schedule 3, line 14	18d	
	e	Add lines 18a through 18d. These are your **total other payments and refundable credits** ▶	18e	
	19	Add lines 17 and 18e. These are your **total payments** ▶	19	
Refund	20	If line 19 is more than line 16, subtract line 16 from line 19. This is the amount you **overpaid**	20	
	21a	Amount of line 20 you want **refunded to you.** If Form 8888 is attached, check here ▶ ☐	21a	
Direct deposit? See instructions.	▶b	Routing number ▶c Type: ☐ Checking ☐ Savings		
	▶d	Account number		
	22	Amount of line 20 you want **applied to your 2020 estimated tax** ▶ 22		
Amount You Owe	23	**Amount you owe.** Subtract line 19 from line 16. For details on how to pay, see instructions ▶	23	0
	24	Estimated tax penalty (see instructions) ▶ 24		

Third Party Designee Do you want to allow another person (other than your paid preparer) to discuss this return with the IRS? See instructions ☐ **Yes.** Complete below. ☐ **No**

(Other than paid preparer) Designee's name ▶ Phone no. ▶ Personal identification number (PIN) ▶

Sign Here Under penalties of perjury, I declare that I have examined this return and accompanying schedules and statements, and to the best of my knowledge and belief, they are true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Joint return? See instructions. Keep a copy for your records.

Your signature	Date	Your occupation	If the IRS sent you an Identity Protection PIN, enter it here (see instr.)
Spouse's signature. If a joint return, **both** must sign.	Date	Spouse's occupation	If the IRS sent your spouse an Identity Protection PIN, enter it here (see instr.)

Phone no. Email address

Paid Preparer Use Only

Preparer's name	Preparer's signature	PTIN	Check if:
EVA CEN EA	EVA CEN EA	[redacted]	☐ 3rd Party Designee
Firm's name ▶ [redacted]	Date 02/22/20		☐ Self-employed
Firm's address ▶ [redacted]	Phone no. [redacted]	Firm's EIN ▶ [redacted]	

Go to *www.irs.gov/Form1040* for instructions and the latest information. Form **1040** (2019)

DAA

DESIGNATION OF AGENT FOR ACCESS TO RECORDS SEALED PURSUANT TO NYCPL §§ 160.50 AND 160.55

I, Xiamin Zeng, Date of Birth [redacted], SS# [redacted], NYSID # [redacted] pursuant to CPL §§ 160.50 and 160.55, hereby designate JAMES E. JOHNSON, Corporation Counsel of the City of New York, or his authorized representative, as my agent to whom all records of any of my arrests may be made available.

I understand that until now the aforesaid records have been sealed pursuant to CPL §§ 160.50 and 160.55, which permits those records to be made available only (1) to persons designated by me, or (2) to certain other parties specifically designated in that statute.

I further understand that the person designated by me above as a person to whom the records may be made available is not bound by the statutory sealing requirements of CPL § 160.50 and 160.55.

The records to be made available to the person designated above comprise all records and papers relating to any and all of my arrests on file with any court, police agency, prosecutor's office or state or local agency that were ordered to be sealed under the provisions of CPL §§ 160.50 and 160.55.

Signature

XIAMIN ZENG
Xiamin Zeng

STATE OF NEW YORK)
: SS.:
COUNTY OF Queens)

On the 8th day of July, 2020, before me personally came Xiamin Zeng, to me known and known to me to be the individual described in and who executed the foregoing instrument, and she acknowledged to me that she executed the same.

NOTARY PUBLIC

FUXIANG YE
Notary Public – State of New York
NO. 01YE6364486
Qualified in Queens County
My Commission Expires Sep 18, 2021

DESIGNATION OF AGENT FOR ACCESS TO SEALED RECORDS PURSUANT TO FAMILY COURT ACT § 375.1

I, XIAMIN ZENG, pursuant to FCA § 375.1, hereby designate JAMES E. JOHNSON, Corporation Counsel of the City of New York, or his authorized representative, as my agent to whom a CERTIFIED COPY of the records of the criminal action, terminated in my favor, entitled In the Matter of 1983 v Prisoner Civil Right, Docket No. [redacted], in Family Court, County of New York, State of New York, relating to my arrest on or about 19-CV-3218, may be made available for photocopying and use in a federal action brought by myself.

I understand that until now the aforesaid records have been sealed pursuant to FCA § 375.1, which permits those records to be made available only (1) to persons designated by me, or (2) to certain other parties specifically designated in that statute.

I further understand that the person designated by me above as a person to whom the records may be made available is not bound by the statutory sealing requirements of FCA § 375.1.

The records to be made available to the person designated above comprise all records and papers relating to my arrest and prosecution in the criminal action identified herein on file with any court, police agency, prosecutor's office or state or local agency that were ordered to be sealed under the provisions of FCA § 375.1

XIAMIN ZENG

STATE OF NEW YORK)
: SS.:
COUNTY OF Queens)

On this 8th day of July, 2020, before me personally came XIAMIN ZENG, to me known and known to me to be the individual described in and who executed the foregoing instrument, and she acknowledged to me that she executed the same.

NOTARY PUBLIC

FUXIANG YE
Notary Public – State of New York
NO. 01YE6364486
Qualified in Queens County
My Commission Expires Sep 18, 2021

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

---x

XIAMIN ZENG,

Plaintiff,

-against-

JOHN CHELL; GARY DENEZZO; GEORGE TAVAREZ; CITY OF NEW YORK; DIEGO ANDRIANZAN; DANIELLE FEBUS,

Defendants.

---x

RELEASE FOR EMPLOYMENT RECORDS

19-CV-3218 (JGK) (KHP)

TO: [redacted]
NAME AND ADDRESS OF EMPLOYER

YOU ARE HEREBY AUTHORIZED to furnish to JAMES E. JOHNSON, Corporation Counsel of the City of New York, attorney for the defendants in the above-captioned case, or to his authorized representative, a **CERTIFIED COPY** of the entire employment record, including but not limited to she application, attendance records, disciplinary records, performance evaluations, workers' compensation records, medical records/nurses records, and/or any doctors notes, and psychiatric/psychological records of XIAMIN ZENG (Date of Birth: [redacted]; SS #: [redacted]), employed by you from 7/15/2016 until 5/16/2017.

Dated: New York, New York
7/8, 2020

XIAMIN ZENG

STATE OF NEW YORK)
: SS:
COUNTY OF Queens)

On the 8th day of July, 2020, before me personally came and appeared XIAMIN ZENG, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that she executed the same.

NOTARY PUBLIC

FUXIANG YE
Notary Public – State of New York
NO. 01YE6364486
Qualified in Queens County
My Commission Expires Sep 18, 2021

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

XIAMIN ZENG,

Plaintiff,

vs.

JOHN CHELL et al

Defendants.

RESPONSES TO INTERROGATORIES AND REQUESTS FOR DOCUMENTS PURSUANT TO FEDERAL RULE OF CIVIL PROCEDURE 33 AND 34

19-CV-3218 (JGK) (KHP)

Pursuant to Rules 26 and 34 of the Federal Rules of Civil Procedure, Plaintiff, Xiamin Zeng (Plaintiff'), submits the following objections and responses to Defendant's First Set of Interrogatories dated June 26, 2020 ("Interrogatories").

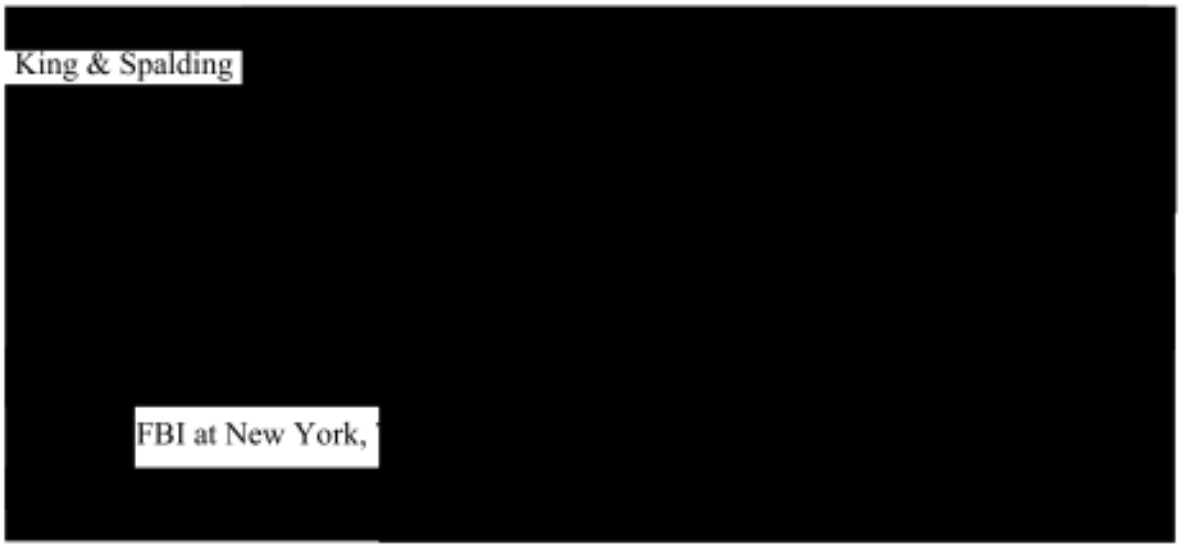
Plaintiff's responses to the Requests reflect Plaintiff's best knowledge after a reasonable search at this point in the litigation. Plaintiff expressly reserves the right to supplement, modify, or add to her responses to the Requests based on her ongoing inquiries.

I, Xiamin Zeng, pursuant to 28 U.S.C. § 1746, hereby declare under penalty of perjury that the following is true and correct:

INTERROGATORIES

1. **Identify all persons who witnessed, were present at, or have knowledge of the Incident, including the home and business addresses and telephone numbers of each witness. If you are unable to identify any of the individuals within the meaning of Local Rule 26.3, describe that individual's physical appearance.**

    1. Plaintiff objects to this interrogatory because it's overly broad.
        a. Subject to and without waiving these objections, Plaintiff responds as follows:



2. Identify any and all statements, signed or unsigned, recorded electronically or otherwise, prepared by plaintiff or any other person that relate to the claims and/or subject matter of this litigation.

2. Plaintiff objects to this interrogatory because it's overly broad.

a. Subject to and without waiving these objections, Plaintiff responds as follows:

On 1/31/2018, Plaintiff received a text message from Detective Danielle Febus saying her son was in custody at the Queens Child Abuse Squad that she needed to pick him up.
On 1/25/2018, [redacted] emailed Plaintiff about Plaintiff's 17-cv-9988 federal complaint against them.
On 04/2018 Plaintiff have a recording obtained from [redacted] Social worker [redacted] which is about ACS/CPS and NYPD's harassment against the plaintiff and her son.

3. Identify any and all statements, signed or unsigned, recorded electronically or otherwise, prepared by the City of New York, or its agents, servants and/or employees, that relate to the claims and/or subject matter of this litigation.

3. Plaintiff objects to this interrogatory because it seeks information not within Plaintiff's control.

4. Identify all injuries claimed by plaintiff as a result of the Incident and the medical, psychiatric, psychological, and other treatment provided, if any. For each such treatment received, identify the provider who rendered the treatment to plaintiff. If no treatment was provided for any claimed injury, so state.

4. Plaintiff objects to this interrogatory because it's already provided as part of Rule 26 disclosures.

a. Subject to and without waiving these objections, Plaintiff responds as follows:

5. Identify all economic injuries claimed by plaintiff as a result of the Incident including, but not limited to, expenditures for medical, psychiatric, or psychological treatment; lost income; property damage; and attorney's fees. Identify the specific amounts claimed for each injury.

5. Plaintiff objects to this interrogatory because it's overly broad and duplicative.

a. Subject to and without waiving these objections, Plaintiff responds as follows:

A. Loss of Liberty Damages

Plaintiff suffers loss of liberty damages. Loss of liberty for false arrest claims in 2019 varies between $13,000 and $394,000. *See Martinez v. Port Auth. of N.Y. & N.J.*, No. 01 CIV. 721 (PKC), 2005 WL 2143333, at *22 (S.D.N.Y. Sept. 2, 2005), *aff'd sub nom. Martinez v. The Port Auth. of New York & New Jersey*, 445 F.3d 158 (2d Cir. 2006) (stating that false arrest awards vary between $10,000 and $300,000 adjusted for inflation for 2005); *Gardner v. Federated Dep't Stores, Inc.*, 907 F.2d 1348, 1353 (2d Cir. 1990) (ordering the remittitur of a $300,000 jury award to $200,000 (roughly $344,000 in 2019 dollars) for approximately 8 hours of imprisonment); *Stile v. City of New York,* 172 A.D.2d 743 (2d Dep't 1991) (ordering a remittitur amount of $150,000 [roughly $381,000 in 2019 dollars] for 28 hours of imprisonment).The NYPD held Ms. Zeng approximately 26 hours and handcuffed her for over an hour. During her incarceration, she did not know where her child was. As such, she could expect a significant award for loss of liberty damages.

B. Emotional Distress Damages

Plaintiff seeks loss of emotional distress damages. Courts have given substantial awards for emotional distress resulting from false arrest. *Gonzalez v. Bratton,* 147 F.Supp.2d 180, 208–09 (S.D.N.Y.2001) (upholding a compensatory award of $250,000 for emotional distress resulting from a false arrest that included a physically invasive search). In *Martinez v. Port Auth. of N.Y. & N.J.*, the Court found that, even though plaintiff was not subject to physical assault by an officer, he still experienced considerable anguish due to his arrest, which included sleeplessness, loss of appetite, anxiety bouts, cessation of social, volunteer, and church activities, ideations of suicide, and concerns about his immigration status. 2005 WL 2143333, at *21. The court held that "an award of $200,000 [in 2005] does not shock the judicial conscience." *Id.* This would be $262,000 in 2019.

As a result of her arrest, Plaintiff was diagnosed with generalized anxiety disorder and major depressive disorder. Her emotional distress is ongoing. In light of the relevant case law, Plaintiff could expect a significant award for emotional distress damages. Plaintiff made a demand of $500,000

6. Identify all of plaintiff's employers for the past ten (10) years, including the name, telephone number and address of each employer and the dates of each employment.

6. Plaintiff objects to this interrogatory because it's disproportionate to the needs of the case and would like to limit the scope of the interrogatory to the past 4 years.

   a. Subject to and without waiving these objections, Plaintiff responds as

follows:

[redacted]

7. Identify all medical providers including, but not limited to, doctors, hospitals, psychiatrists, psychologists, social workers and other counseling services, who have rendered treatment to the plaintiff within the past ten (10) years.

7. Plaintiff objects to this interrogatory because it's disproportionate to the needs of the case and duplicative.

   a. Subject to and without waiving these objections, Plaintiff responds as follows:

See response to Interrogatory 4

8. Has plaintiff applied for worker's compensation within the past ten (10) years? If so, identify each employer who provided worker's compensation to plaintiff.

8. Plaintiff responds as follows:

None

9. Has plaintiff applied for social security disability benefits within the past ten (10) years? If so, identify each state, city, or other jurisdiction that provided social security disability benefits to plaintiff.

9. Plaintiff responds as follows:

None

10. Has plaintiff applied for Medicare and/or Medicaid within the past ten (10) years? If so, identify each state, city or other jurisdiction that provided Medicare and/or Medicaid to plaintiff.

10. Plaintiff responds as follows:

Yes, [redacted] New York State of Health.

11. Has plaintiff made a claim with any insurance carrier for physical, mental or emotional injuries within the past ten (10) years? If so, identify each claim by date, injury and insurance carrier.

11. Subject to and without waiving these objections, Plaintiff responds as follows:

12. Identify all government agencies to whom plaintiff made complaints regarding the Incident including, but not limited to, the Civilian Complaint Review Board ("CCRB") and the Internal Affairs Bureau ("IAB") of the New York City Police Department.

12. Plaintiff objects to this interrogatory because it's overly broad.

a. Subject to and without waiving these objections, Plaintiff responds as follows:

NYC Comptroller, NYC Public Advocate, DOJ Office for Victims of Crime, FBI and Congresswoman Nydia Velazquez et al.

13. Identify each occasion on which plaintiff has been arrested other than the Incident that is the subject of this lawsuit, including the date of the arrest, the charges for which the plaintiff was arrested, and the amount of time that plaintiff spent incarcerated.

13. Plaintiff objects to this interrogatory because it's disproportionate to the needs of this case.

a. Subject to and without waiving these objections, Plaintiff responds as follows:

On 5/3-5/4/2017, ACS claimed that plaintiff violated ACS's order.
On 1/24-1/31/2019, ACS claimed that plaintiff violated ACS's order.
On 3/4-3/5/2019, ACS claimed that plaintiff violated ACS's order again.

14. Identify each occasion in which plaintiff has been convicted of a felony or misdemeanor, including the date of the conviction, the charges of which plaintiff was convicted, and amount of time that plaintiff spent incarcerated as a result of each conviction.

14. Plaintiff responds as follows:

None

15. Identify each lawsuit to which plaintiff has been a party, including the court in which the matter was pending, the docket or index number, and the disposition of the matter.

15. Plaintiff objects to this interrogatory because it's overly broad.

a. Subject to and without waiving these objections, Plaintiff responds as follows:

Zeng v. Chell, 19 –CV-3218 (pending); Zeng v. City, 20-CV-0451 (pending);
Zeng v. NYCHA, 18-CV-12008 (pending); Zeng v. Augustin, 17-cv-9988 (dismissed);
ACS v. Zeng, [redacted] (dismissed); ACS v. Zeng [redacted] (dismissed);
Zeng v. Liu, [redacted] (Zeng won); Zeng v. Liu, [redacted] (Zeng won).

16. Identify each occasion on which plaintiff has given testimony or statements regarding the subject of this lawsuit.

16. Plaintiff objects to this interrogatory because it's vague and ambiguous.

a. Subject to and without waiving these objections, Plaintiff responds as follows:

Depositions requested by the defendant for her 17-cv-9988 case.

17. Identify all treating physicians and other medical providers that plaintiff intends to call at the time of trial.

17. Plaintiff objects to this interrogatory because it is premature and further discovery is needed for answering this interrogatory.

a. Subject to and without waiving these objections, Plaintiff responds as follows:

[redacted]

18. Identify all experts that plaintiff expects to call at the time of trial, all correspondence between counsel for plaintiff and any such experts, any notes taken by any such experts and provide all disclosures required pursuant to Federal Rule 26(a)(2).

18. Plaintiff objects to this interrogatory because it is premature and further discovery is needed for answering this interrogatory.

19. Identify all documents prepared by plaintiff, or any other person that relate to the Incident, claims and subject matter of this litigation.

19. Plaintiff objects to this interrogatory because it is overly broad and duplicative.

20. Identify all Freedom of Information Law requests and any responses thereto, made by plaintiff or by anyone on plaintiff's behalf, concerning plaintiff's claims in this litigation.

20. Plaintiff responds as follows:

None

DOCUMENT REQUESTS

1. Produce all the documents identified in the preceding Interrogatories.

1. Plaintiff objects to this interrogatory because it is overly broad and duplicative.

a. Subject to and without waiving these objections, Plaintiff directs defendant to documents attached.

2. Produce all documents regarding the Incident, including documents concerning plaintiff's arrest and criminal prosecution (if any), the minutes of any Grand Jury proceedings and criminal court transcripts, and any and all other documents concerning the Incident that are in plaintiff's possession, custody or control.

2. Plaintiff objects to this interrogatory because it is overly broad and duplicative.

a. Subject to and without waiving these objections, Plaintiff directs defendant to Document Request 1.

3. Produce all medical records including, but not limited to, records of doctors, hospitals, psychiatrists, psychologists, social workers, and other counseling services, in plaintiff's possession, custody, or control for treatment received by plaintiff since the Incident and for the five years prior to the Incident, including treatment for any injury resulting from the Incident.

3. Plaintiff objects to this interrogatory because it is overly broad and duplicative.

a. Subject to and without waiving these objections, Plaintiff responds as follows:

See response to Interrogatory 4 and medical records released by HIPPA waivers.

4. Produce all photographs and other audio-visual materials documenting the Incident, the scene of the Incident, and all injuries that resulted from the Incident, including injuries to person and property. Defendants request exact duplicates of the original photographs and audio-visual materials.

4. Plaintiff objects to this interrogatory because it is overly broad and unduly burdensome.

5. Produce all documentation of damages that plaintiff alleges stem from the Incident, including, but not limited to, expenditures for medical, psychiatric, or psychological treatment; lost income; property damage; and attorneys fees. Documentation includes, but is not limited to, paid and unpaid bills, original purchase receipts, cancelled checks, charge slips, appraisals, and warranties.

5. Plaintiff objects to this interrogatory because it is duplicative and

a. Subject to and without waiving these objections, Plaintiff responds as

follows:

See response to Interrogatory 5

6. Produce copies of all subpoenas served on any party, or any individual or entity, concerning this litigation.

6. Plaintiff objects to this interrogatory because it is premature and further investigation is needed to respond to this document request.

7. Produce all documents received in response to any subpoenas served.

7. Plaintiff objects to this interrogatory because it is premature and further investigation is needed to respond to this document request.

8. Produce all documents that relate to all complaints made by plaintiff to any government agency regarding the incident including, but not limited to, the CCRB and IAB of the New York City Police Department.

8. Plaintiff objects to this interrogatory because it is duplicative.

a. Subject to and without waiving these objections, Plaintiff direct defendant to Interrogatory 12.

9. If the plaintiff is claiming lost income in this action, produce plaintiff's federal and state income tax returns since the Incident and for the five years prior to the Incident.

9. Plaintiff objects to this interrogatory because it is duplicative.

a. Subject to and without waiving these objections, Plaintiff directs defendant to release for employment records.

Attached the 2016 -2019 tax returns

10. Produce: (a) all expert disclosures required pursuant to Federal Rule 26(a)(2); (b) any drafts of any reports or other disclosures required by Fed. R. Civ. P. 26(a)(2); (c) all correspondence between plaintiff's counsel, or anyone acting for or on behalf of plaintiff or plaintiff's counsel, and any experts identified in response to Interrogatory No. 18, including, but not limited to, any documents reflecting any fee agreements and any instructions plaintiff's counsel has provided to the expert

regarding the expert's expected testimony and/or examination of plaintiff; and (d) any notes taken by any experts identified in response to Interrogatory No. 18 regarding plaintiff, plaintiff's counsel, the incident alleged in the complaint, this lawsuit, the expert's expected testimony or the expert's retention by plaintiff's counsel in this action.

10. Plaintiff objects to this interrogatory because it is premature and further investigation is needed to respond to this document request.

11. Complete and provide the annexed blank authorizations for release of plaintiff's medical records including, but not limited to, records of doctors, hospitals, psychiatrists, psychologists, social workers and other counseling services for treatment received by plaintiff since the Incident and for the five years prior to the Incident, including treatment for any injury resulting from the Incident.

11. Subject to and without waiving these objections, Plaintiff responds as follows:

Attached the plaintiff's authorizations for release of plaintiff's medical records

12. Complete and provide the annexed blank authorization for access to plaintiff's records that may be sealed pursuant to N.Y. C.P.L. §§ 160.50 and 160.55. Note that the authorization for access to plaintiff's records that may be sealed pursuant to N.Y. C.P.L.160.50 and 160.55 that is annexed hereto differs from the authorization that may have been provided at the outset of this litigation in that it is not limited to documents pertaining to the arrest and/or prosecution that is the subject of this litigation.

12. Subject to and without waiving these objections, Plaintiff responds as follows:

Attached the plaintiff's authorization for access to plaintiff's records that may be sealed pursuant to N.Y. C.P.L. §§ 160.50 and 160.55

13. Complete and provide the annexed blank authorizations for release of employment records for each of plaintiff's employers for the past ten (10) years.

13. Subject to and without waiving these objections, Plaintiff responds as follows:

Attached the plaintiff's authorizations for release of employment records

14. Complete and provide the annexed blank authorization for the unemployment records, if any, of plaintiff.

14. Subject to and without waiving these objections, Plaintiff responds as follows:

Attached the plaintiff's authorization for the unemployment records

15. Complete and provide the annexed blank authorizations for insurance carriers with whom plaintiff has made claims within the past ten (10) years.

15. Plaintiff objects to this interrogatory because it is overly broad and duplicative.

a. Subject to and without waiving these objections, Plaintiff directs defendant to release for Medicaid records

16. Complete and provide the annexed blank authorization for the records of social security disability benefits, if any, received by plaintiff.

16. Subject to and without waiving these objections, Plaintiff responds as follows:

None

17. Complete and provide the annexed blank authorization for plaintiff's Medicare and/or Medicaid records.

17. Subject to and without waiving these objections, Plaintiff responds as follows:

Attached the plaintiff's authorization for plaintiff's Medicaid records

18. Complete and provide the annexed blank authorization for release of the Family Court records.

18. Subject to and without waiving these objections, Plaintiff responds as follows:

Attached the plaintiff's authorization for release of the Family Court records

Xiamin Zeng
Plaintiff *Pro Se*

Dated: 7/8/2020

To: Via U.S. Mail
Stephanie De Angelis Esq.,
New York City Law Department
100 Church Street, Room 3-202
New York, NY 10007

Home Help

History: Select a previously visited page

Clients Case Management Providers Prior Authorization Claims Third Party Financial MARS eCommerce SURS Reference Administration

Client

Client Search > **Client: XIAMIN ZENG - CIN: [redacted]**

Print

Summary Eligibility Previous Information Principal Provider Spend-down Exception / Restriction UT / Dx-Rpt TPL Third Party Address History PCP History

Client

Trans District: 78-NY HBE
SSN: [redacted]
CBIC Card Code:
CBIC Sequence Number: [redacted]
Disability Accommodation Indicator Code:

Date Added: [redacted]
Date of Birth: [redacted]
Age: 37
Date of Death:

Change Date: 01/31/2018
Sex: F-FEMALE
Relation to NH:
Language Written: ENG-ENG
Language Spoken: ENG-ENG

Address

Address Line 1: [redacted]
Address Line 2:
City: NEW YORK
Data Origin Code: H-HBE
State: NY
Residential County Code: 60-NEW YORK
Postal Code: [redacted]
Confidentiality Code:
Phone Number: [redacted]

Available Data

Restriction Exception MC Exemption Principal Provider Third Party Spenddown

Eligibility

14 results. Displaying 1-10 1 | 2 | Next>> | View

Begin Date	End Date	Case Number	Trans Dist	Case Worker	TMA Indicator	Coverage	Aid Category	Fiscal Dist	Office	Status	Override	Change Date	Data Origin Code	Case Type	Ca Co
05/01/2019	12/31/9999	0004786490	78-NY HBE		B-CLNT NO TH	30-MCAID PCP	32-LIF W DEP	66-NY CITY		07-ACTIVE		03/19/2019	H-HBE		
03/01/2018	04/30/2019	0004786490	78-NY HBE		B-CLNT NO TH	30-MCAID PCP	32-LIF W DEP	66-NY CITY		20 CLOSED		03/19/2019	H-HBE		
12/01/2017	02/28/2018	0004786490	78-NY HBE		B-CLNT NO TH	01-ALL BENEFI	32-LIF W DEP	66-NY CITY		07-ACTIVE		01/31/2018	H-HBE		
05/01/2017	11/30/2017	0004786490	78-NY HBE		B-CLNT NO TH	30-MCAID PCP	32-LIF W DEP	66-NY CITY		20 CLOSED		11/15/2017	H-HBE		

[redacted]

MC (Managed Care)

Provider ID	Provider Name	Plan Code	Package	Begin Date	End Date	Trans District	Case Worker	Change Date	Data Origin Code	PCP Subscriber	PCP Member	PCP Group Code	PCP Policy	HIOS ID
01479620	HEALTH FIRST PHSP INC	SF HFPHSP	66-BP66	03/01/2019	04/30/2019	66-NY CITY	834HP	02/12/2019	H-HBE	[redacted]				
01751046	FIDELIS CARE	SF-FIDEL MMC	66-BP66	05/01/2017	11/30/2017	66-NY CITY	834HP	04/11/2017	H-HBE					
01751046	FIDELIS CARE	SF-FIDEL MMC	66-BP66	03/01/2018	02/28/2019	66-NY CITY	511H	02/12/2019	H-HBE					
01751046	FIDELIS CARE	SF-FIDEL MMC	66-BP66	05/01/2019	12/31/9999	66-NY CITY	511H	06/18/2019	H-HBE					

MC (Managed Care) Coverages

80 results. Displaying 1-10 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | Next>> | View

Effective Date	Plan Code	Package	Coverages
[redacted]	SF-HFPHSP	66-BP66	A-INPT HOSP

Once again, we are pleased to have this opportunity to work with you. Please call me whenever you have questions or comments during the course of our representation.

Very truly yours,

WILMER CUTLER PICKERING HALE AND DORR LLP

By: David Bassett
David B. Bassett
Partner

ACKNOWLEDGED AND AGREED:

Xiamin Zeng

Date: 7/11/2018

NYCHA hired WilmerHale 2016

All Images Videos News Short videos Sho

Patch
https://patch.com

NYCHA Spends $10M On Lawyers As Feds Investigate Agency: Report

Oct 9, 2018 — NYCHA engaged WilmerHale after its own lawyers failed to block federal subpoenas for mold and lead paint inspection records, the Daily News ...

New York Daily News
https://www.nydailynews.com

Law firm NYCHA hired to fend off investigations of failures racks up ...

Oct 9, 2018 — The authority hired the WilmerHale firm in the spring of 2016 to deal with a wide-ranging investigation by the Manhattan U.S. attorney's ...

New York Daily News
https://www.nydailynews.com

NYCHA board secretly voted again and again to spend $27 ...

Wilmer Hale was hired to represent the authority ... 2016 through January) and Stanley Brezenoff ... hired by

NYCHA hired WilmerHale